

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18501

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NORMAN JONES JR.				2. Date of Death Month Day Year JUNE 07 1999				3. Time of Death 3:55 am																				
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A																				
Funeral Director	5. Social Security Number 214 44 9222		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 18, 1946		9. Birthplace (State or Foreign Country) Maryland																				
	Usual Residence of Decedent																												
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																				
	10e. Street and Number 4216 - 6th Street 2nd Floor				10f. Zip Code 21225		10g. Citizen of What Country? U.S.																						
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White																				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Produce Manager				16b. Kind of Business/Industry Stop, shop & Save Grocery Store																				
	17. Father's Name (First, Middle, Last) Norman L. Jones Sr.				18. Mother's Name (First, Middle, Maiden Surname) Thelma Glover																								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Steven Jones / Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1402 Cypress Street Apt. 5 Baltimore, Md. 21226																								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 6/11/99		20c. Location - City or Town, State Baltimore, Maryland																						
	21. Signature of Funeral Service Licensee <i>Richard E. Davis</i>				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225																								
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																												
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>SEPTICEMIA</td> <td rowspan="4">Approximate Interval Between Onset and Death 5 DAYS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>CELLULITIS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td rowspan="2"></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="2"></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	SEPTICEMIA	Approximate Interval Between Onset and Death 5 DAYS	Due to (or as a consequence of):		b.	CELLULITIS	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.			Due to (or as a consequence of):		d.		
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	Due to (or as a consequence of):																												
d.																													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC DILATED CARDIOMYOPATHY HYPERTENSION DIABETES MELLITUS								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Dr. [Signature]</i> M.D. RESIDENT HOUSESTAFF		29c. License number P 11949		29d. Date signed (Month, Day, Year) 7th JUNE 1999																					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ABHAY MOUHEKAR, HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST., BALTIMORE																													
31. Date filed (Month, Day, Year) JUN 9 1999				32. Registrar's Signature <i>[Signature]</i>																									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

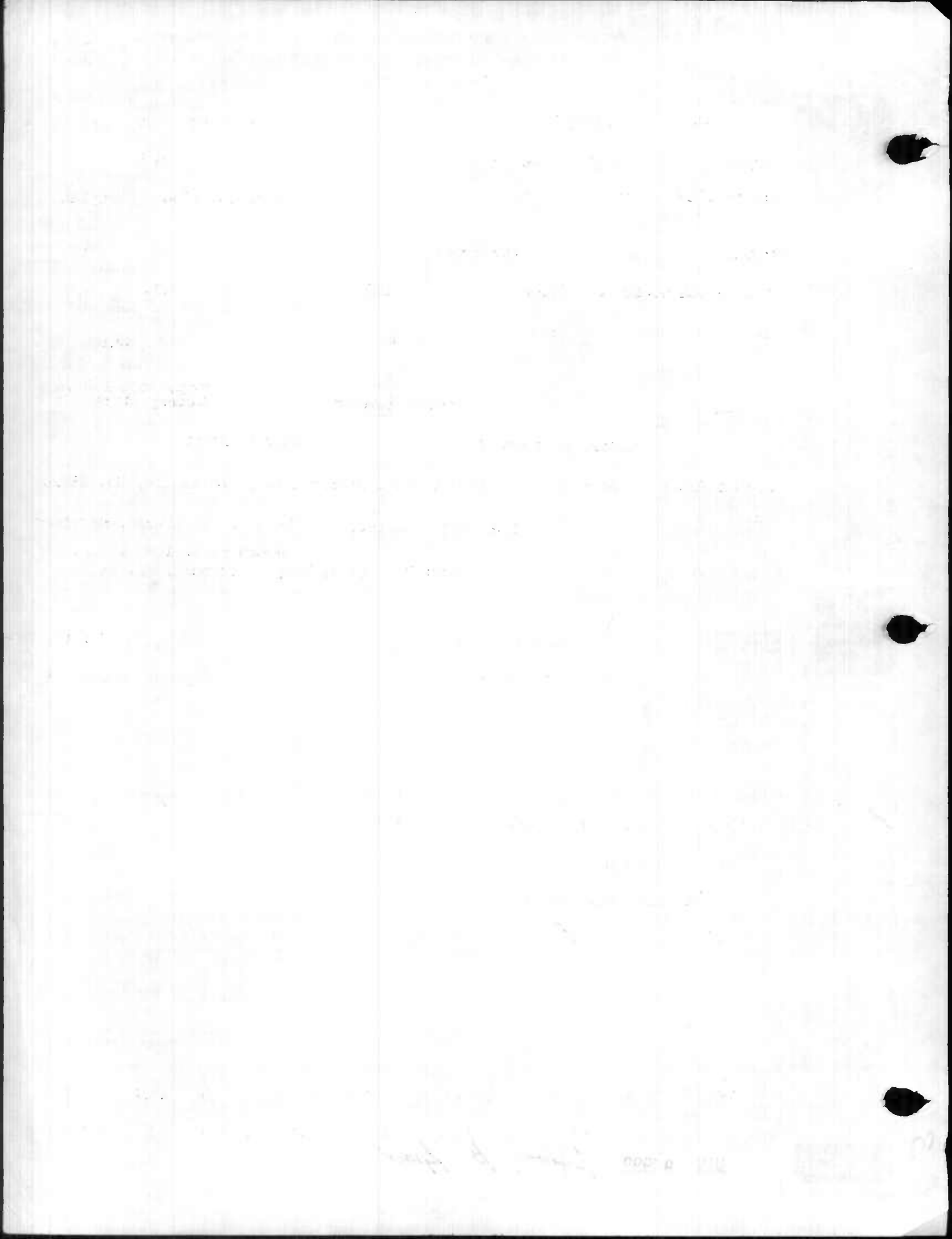
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #5 PER F.H. G772 6-16-99 WR.

Certificate of Death

Reg. No. 99 18502

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) Elizabeth Lillian Kondner				2. Date of Death Month: June, Day: 8, Year: 1999				3. Time of Death 2:50 a.m.				
	4a. Facility Name (If not institution, give street and number) Charlestown Nursing Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 215-03-1715		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) June 11, 1917		9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10e. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number 1073 Southridge Road				10f. Zip Code 21228		10g. Citizen of What Country? United States						
	11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 Collage (1-4 or 5+): 0				16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Service			16b. Kind of Business/Industry government					
	17. Father's Name (First, Middle, Last) Leon Nackfalski				18. Mother's Name (First, Middle, Maiden Surname) Helen Wisniewski								
	19a. Informant's Name/Relationship (Type, Print) Richard D. Kondner - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1073 Southridge Road, Baltimore, Maryland 21228								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 6/11/99						
	21. Signature of Funeral Service Licensee Ann Y. Zink				22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland 21229								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death years		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
										24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier				29c. License number 047447		29d. Date signed (Month, Day, Year) June 8, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Czers 711 Maiden Choice Lane Catonsville Maryland													
31. Date filed (Month, Day, Year) JUN 9 1999		32. Registrar's Signature Beverly B. Sparks											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18503

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Helen Kirby

2. Date of Death

June 4 1999

Day

Year

3. Time of Death

9:15 pm

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Geriatric Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212-01-1273

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

FEB. 8, 1901

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

DUNDALK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

103 CENTER PLACE APT. 129

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Summa)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

MARY HERHEI - FRIEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1807 DUNMERE ROAD BALTIMORE, MARYLAND 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE-WASHINGTON CREMATORY

Date

6-7-99

20c. Location - City or Town, State

LAUREL, MARYLAND

21. Signature of Funeral Service Licensee

Elizabeth L. Selinski

22. Name and Address of Facility

BRADLEY-ASHTON-MATTHEWS FUNERAL HOME, INC.
2134 WILLOW SPRINGS ROAD BALTIMORE, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. gangrene Left foot

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jimmy Edmond MD

29c. License number

D0053124

29d. Date signed (Month, Day, Year)

June 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jimmy Edmond MD 5505 Hopkins Bayview Circle Baltimore Maryland 21224

31. Date filed (Month, Day, Year)

JUN 9 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE GARDEN

wrc
99-3196-510
HECTOR
THOMAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #1 PER MD G772 6-11-99 WR.

Certificate of Death

Reg. No. 99-18504

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HECTOR THOMAS Mc NEIL HECTOR THOMAS					2. Date of Death Month Day Year JUNE 05, 1999		3. Time of Death 6:52 PM.				
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL					4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A				
Funeral Director	5. Social Security Number 241 22 7179		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 18, 1921		9. Birthplace (State or Foreign Country) North Carolina			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location GLEN ARM			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number 5440 HILLRISE ROAD				10f. Zip Code 21057			10g. Citizen of What Country? U.S. OF A.				
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: AMERICAN INDIAN				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) UNKNOWN		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER			16b. Kind of Business/Industry CARPENTRY						
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) DOUGAL THOMAS					18. Mother's Name (First, Middle, Maiden Surname) BEATRICE McNEIL						
	19a. Informant's Name/Relationship (Type, Print) HECTOR THOMAS, JR. (SON)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10394 FAULKNER RIDGE CIR. COLUMBIA, MD. 21057						
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VET. CEM.			20c. Location - City or Town, State BALTO. OWINGS MILLS, MD. Co.		20d. Date 6/11/99				
	21. Signature of Funeral Service Licensee Lewis T. Gwynn					22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD.						
Physician /Medical Examiner	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
State Registrar	29b. Signature and title of certifier [Signature]					29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 06, 1999				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201											
State Registrar	31. Date filed (Month, Day, Year) JUN 09 1999		32. Registrar's Signature [Signature]									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18505

AMENDED ITEM #7 PER FH G772 6/11/99 AH

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH MYERS		2. Date of Death Month Day Year JUNE 04 1999		3. Time of Death 14:50
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 216-44-0686	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 54 Yrs.	8. Date of Birth (Month, Day, Year) JULY 3, 1944	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
10e. State Maryland		10b. County Baltimore	10c. City, Town or Location Dundalk		10d. Inside City Limits 1 Yes 2 No
10e. Street and Number 1934 Guyway		10f. Zip Code 21222		10g. Citizen of What Country? United States	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	
14. Race - American Indian, Black, White, etc. White		15. Decedent's Education (Specify only highest grade completed) 12 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cake Decorator	
16b. Kind of Business/Industry Bakery		17. Father's Name (First, Middle, Last) John Francis Roesch		18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Nelson	
19a. Informant's Name/Relationship (Type, Print) Mary Zarr / Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1934 Guyway Dundalk, Maryland 21222			
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Location - City or Town, State Towson, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CHRONIC OBSTRUCTIVE PULMONARY DISEASE					Approximate Interval Between Onset and Death
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 No					24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier 		29c. License number 97614		29d. Date signed (Month, Day, Year) JUNE 4, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARESH CITRATAN John Hopkins Bayview Medical Center Baltimore MD 21224					
31. Date filed (Month, Day, Year) JUN 09 1999		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number
97614

29d. Date signed (Month, Day, Year)
JUNE 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NARESH CITRATAN John Hopkins Bayview Medical Center Baltimore MD 21224

31. Date filed (Month, Day, Year)
JUN 09 1999

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended Item#8 per FH G772 6/3/99 EW

Reg. No. 99 18506

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELSIE MUGENT				2. Date of Death Month Day Year MAY 27, 1999				3. Time of Death 5:04pm									
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE CITY									
Funeral Director	5. Social Security Number 213-20-3465		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) 1925 AUG. 1, 1999		9. Birthplace (State or Foreign Country) MD.									
	Usual Residence of Decedent																	
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number 5220 YORK RD.				10f. Zip Code 21212				10g. Citizen of What Country? U.S.A.										
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME										
17. Father's Name (First, Middle, Last) WILLIAM LLOYD FARLOW					18. Mother's Name (First, Middle, Maiden Surname) MARY JOSEPHINE BIERSHING													
19a. Informant's Name/Relationship (Type, Print) LUCILLE WARING STEINER/SISTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2807 HAMPDEN AVE. BALTIMORE, MD. 21211													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) OAK LAWN CEMETERY			Date 6/1/99		20c. Location - City or Town, State BALTIMORE, MD.										
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE. BALTIMORE, MD. 21224													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. INFARCTED BOWEL Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): </td> <td colspan="8"> Approximate Interval Between Onset and Death a. ONE WEEK b. ONE WEEK c. d. </td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. INFARCTED BOWEL Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	Approximate Interval Between Onset and Death a. ONE WEEK b. ONE WEEK c. d. 							
Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. INFARCTED BOWEL Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	Approximate Interval Between Onset and Death a. ONE WEEK b. ONE WEEK c. d. 																	
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)														
28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier  MD				29c. License number P 12557				29d. Date signed (Month, Day, Year) MAY 27, 1999										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAFAEL DODO, 5601 LOCHRAVEN BLVD, BALTIMORE, MD 21239																		
31. Date filed (Month, Day, Year) JUN 9 1999																		
32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 302.58.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18507

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Perry				2. Date of Death Month Day Year 5 30 99		3. Time of Death 359 PM		
	4a. Facility Name (If not institution, give street end number) Mercy Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 214-18-6227		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) 7-4-21		
	9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street end Number 6713 RANSOME PARK		10f. Zip Code 21207		10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4or 5+) -0-		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE		16b. Kind of Business/Industry JANITORIAL		17. Father's Name (First, Middle, Last) JOHN D. PERRY		18. Mother's Name (First, Middle, Maiden Surname) JULIA HICKS	
19a. Informant's Name/Relationship (Type, Print) RUTH D. PERRY (SISTER)		19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6713 RANSOME PARK RANDALLSTOWN, MD. 21207		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Location - City or Town, State 6-7-99 BALTIMORE, MARYLAND	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Cerebral Hemorrhage Due to (or as a consequence of): b. Small Vessel Disease Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Diabetes		Approximate Interval Between Onset and Death 2 weeks			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street end Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number P11196		29d. Date signed (Month, Day, Year) 5/30/99			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Richard Royal MD Mercy Medical Center		31. Date filed (Month, Day, Year) JUN 9 1999		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Wash. & ...

2001. 11.10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

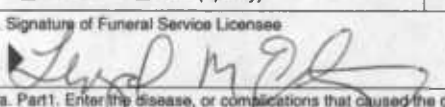
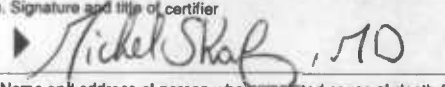
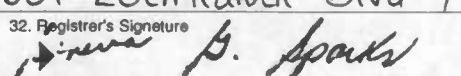
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18508

AMENDED ITEM #8 PER FH G772 6/9/99 AH

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNIE		2. Date of Death Month Day Year JUNE 04 1999		3. Time of Death 8:00am
	4a. Facility Name (If not institution, give street and number) GOO3 SAMARTIAN HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
Funeral Director	5. Social Security Number 217-22-0183	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 9-17-99 1904		9. Birthplace (State or Foreign Country) SC.		
Usual Residence of Decedent					
10a. State MD.		10b. County		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 6211 CATALPHA RD.			10f. Zip Code 21214		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry HOME	
17. Father's Name (First, Middle, Last) BENJAMIN PINKNEY			18. Mother's Name (First, Middle, Maiden Surname) HAGER PINKNEY		
19a. Informant's Name/Relationship (Type, Print) BEATRICE E. WINDER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6211 CATALPHA RD BALTIMORE, MARYLAND 21214		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) mt. zion cemetery		20c. Location - City or Town, State 6-10-99 BALTIMORE MARYLAND	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial infarction Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Hypertension					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  MD		29c. License number P11391		29d. Date signed (Month, Day, Year) June 4, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHEL SKAF, 5601 Loch Raven Blvd, Baltimore, MD 21239.					
31. Date filed (Month, Day, Year) JUN 9 1999		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18509

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James H. Rodgers, Sr.				2. Date of Death Month Day Year June 6, 1999				3. Time of Death 1:25 AM	
	4a. Facility Name (If not institution, give street and number) 9 Russ Court				4b. City, Town, or Location of Death Edgemere				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-07-9982		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) July 23, 1918		9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Edgemere	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 9 Russ Court		10f. Zip Code 21219		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (14 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Agent		16b. Kind of Business/Industry Life Insurance Comp.					
	17. Father's Name (First, Middle, Last) Howard Rodgers				18. Mother's Name (First, Middle, Maiden Surname) Marion Cook					
	19a. Informant's Name/Relationship (Type, Print) Wife Mrs. Helen A. Rodgers				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Russ Ct. Edgemere, Maryland 21219					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery 6/9/1999		20c. Location - City or Town, State Baltimore, MD					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Extensive Stage Small Cell Lung Cancer Due to (or as a consequence of):								Approximate Interval Between Onset and Death 1 mo	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  M.D.		29c. License number D45390		29d. Date signed (Month, Day, Year) 6/8/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mrs. Helen A. Rodgers 6830 Hospital Dr. #206, Baltimore, MD 21237										
31. Date filed (Month, Day, Year) JUN 09 1999		32. Registrar's Signature  B. Sparks								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18511

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Joseph Santer</i>				2. Date of Death Month: <i>April</i> Day: <i>27</i> Year: <i>99</i>		3. Time of Death <i>3:59 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>9640 Barrell House Road, #A</i>				4b. City, Town, or Location of Death <i>Laurel</i>		4c. County of Death <i>Howard</i>	
Funeral Director	5. Social Security Number <i>035-14-0175</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>76</i> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <i>Aug. 29, 1922</i>	9. Birthplace (State or Foreign Country) <i>Portugal</i>
	Usual Residence of Decedent				10a. State <i>Maryland</i>		10b. County <i>Howard</i>	
To Be Completed by Funeral Director	10c. City, Town or Location <i>Laurel</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>9640 Barrel House Road, #A</i>	
	10f. Zip Code <i>20723</i>				10g. Citizen of What Country? <i>U.S.A.</i>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Jockey</i>		16b. Kind of Business/Industry <i>Horse Racing</i>	
	17. Father's Name (First, Middle, Last) <i>Jose Gouveia</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Maria Gouvias</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Marie A. Triado/friend</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9640 Barrel House Road, #A, Laurel, MD 20723</i>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>in state</i>				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>				22. Name and Address of Facility <i>State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Cancer of Stomach with metastases</i>				Due to (or as a consequence of):		Approximate Interval Between Onset and Death <i>4 months</i>	
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>Cancer of Stomach with metastases</i>				Due to (or as a consequence of):			
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature] M.D.</i>		29c. License number <i>D24721</i>		
				29d. Date signed (Month, Day, Year) <i>5/27/99</i>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>SYED SADIQ, 14333 Laurel Bowie Rd. St 208 LAUREL MD 20708</i>								
31. Date filed (Month, Day, Year) <i>JUN 09 1999</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

TOP SECRET - FRODO BAGGINS

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18512

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES J. SWARTZ

2. Date of Death
Month Day Year

JUNE 7 1999

3. Time of Death

7:31 PM

4e. Facility Name (If not institution, give street and number)

GILCHRIST NURSING CENTER

4b. City, Town, or Location of Death

BALTIMORE CO

4c. County of Death

BALTIMORE

5. Social Security Number

218305726

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

NOV 17 1934

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE CO. MD.

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15 HOLLYBROOK COURT

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11th

College (1-4 or 5+)
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

DEPT. STORE

17. Father's Name (First, Middle, Last)

MARIO GENTILE

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER ANZALONE

19a. Informant's Name/Relationship (Type, Print)

EDWARD S. SWARTZ

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 HOLLYBROOK CT. BALTO MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAKLAWN CEM.

Date

6/11/99

20c. Location - City or Town, State

BALTO CO.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME, CHFD.
7527 HARTFORD RD. BALTO MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. multiple cerebral infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Dr. Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

June 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley GENC 6701 N. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

JUN 08 1999

32. Registrar's Signature

[Signature] B. Sparks

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

SWARTZ, FRANCES 6-7-99 7:31 PM

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roger Keith Sisler				2. Date of Death Month Day Year JUNE 8, 1999		3. Time of Death 0005 AM	
	4a. Facility Name (If not institution, give street and number) GARRETT COUNTY MEMORIAL HOSPITAL				4b. City, Town, or Location of Death OAKLAND		4c. County of Death GARRETT	
Funeral Director	5. Social Security Number 232-72-0433		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) 12-03-1945	
	9. Birthplace (State or Foreign Country) Maryland		10a. State West Virginia		10b. County Preston		10c. City, Town or Location Horseshoe Run	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number Rt. 1		10f. Zip Code 26716		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) -----		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Longwall Operator		16b. Kind of Business/Industry Mining			
	17. Father's Name (First, Middle, Last) Chauncy C. Sisler				18. Mother's Name (First, Middle, Maiden Surname) Margaret McCune			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Nancy G. Sisler (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1 Horseshoe Run, West Virginia 26716			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Blooming Run Cemetery		20c. Date 6-12-99		20d. Location - City or Town, State Friendsville, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee J. Wayne Osterling				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Sclerosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month/Day/Year) 6/7/99		28b. Time of Injury 2240 M		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred Subject struck by rock in coal mine		28e. Location (Street and Number or Rural Route Number, City or Town, State) Postal Horseshoe Run West Virginia					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Theodore M. King				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JUNE 8, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
State Registrar	31. Date filed (Month, Day, Year) JUN 9 1999		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18514

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH L. SMITH				2. Date of Death Month Day Year 05-04-99		3. Time of Death 10:00 AM	
	4e. Facility Name (If not institution, give street and number) 122 Foxchase Court Apt. 1				4b. City, Town, or Location of Death Largo		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 309-16-8674		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 03-06-1914	9. Birthplace (State or Foreign Country) Kentucky
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Prince George's	10c. City, Town or Location Largo			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 122 Foxchase Court Apt. 1				10f. Zip Code 20774		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Private	
	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Unknown			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jean A. Morton/friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Foxchase Court Apt. 1 Largo, MD 20774			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 5/14/99		20c. Location - City or Town, State Beltsville, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave., NW Wash., DC 20011			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardiorespiratory Arrest Due to (or as a consequence of): Congestive Heart Failure b. Due to (or as a consequence of): c. Failure to Thrive Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D47604		29d. Date signed (Month, Day, Year) May 6, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sobhan Matthew 2905 Mitcheville, MD 20716								
31. Date filed (Month, Day, Year) JUN 9 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18515

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE M. DE SIMONE

2. Date of Death

JUNE 4 1999

3. Time of Death

5:15 PM

4a. Facility Name (If not institution, give street and number)

3011 HARVIEW AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

MD

Funeral
Director

5. Social Security Number

213-20-1425

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 18, 1910

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE, MD

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

3011 HARVIEW AVE

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

ORAZIO TOTARO

18. Mother's Name (First, Middle, Maiden Surname)

FLIPPA BOMBARA

19a. Informant's Name/Relationship (Type, Print)

BENEDICT J. DESIMONE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4101 MARX AVE, BALTO. MD. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY REDEEMER

Date

6/8/99

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME, CHTD.

7527 HARFORD RD. BALTO MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Lymphoma (Non-Hodgkins')

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D52810

29d. Date signed (Month, Day, Year)

June 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Shepard MD, 6569 North Charles St., Baltimore, MD 21204

31. Date filed (Month, Day, Year)

JUN 08 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18516

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cyrethia I. Taylor				2. Date of Death Month Day Year June 5, 1999		3. Time of Death 18:20	
	4a. Facility Name (If not institution, give street and number) 810 Thimble Berry Road				4b. City, Town, or Location of Death Middle River		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 225-30-0524		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) July 18, 1927	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Middle River	
To Be Completed by Funeral Director	10e. Street and Number 810 Thimble Berry Road		10f. Zip Code 21220		10g. Citizen of What Country? United States		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Luther Henry Morris		18. Mother's Name (First, Middle, Maiden Surname) Lottie Morris		19a. Informant's Name/Relationship (Type, Print) Faye Williams/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Thimble Berry Road Middle River, MD 21220	
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 6/9/99	
	21. Signature of Funeral Service Licensee <i>Patricia M. Fleming</i>		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Alzheimers Disease</i> Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760, MS 145	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>McCauley</i>		29c. License number D28177		29d. Date signed (Month, Day, Year) 6/7/99	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6801 Belair Rd. Balto. Md. 21206		31. Data filed (Month, Day, Year) JUN 09 1999		32. Registrar's Signature <i>B. Sparks</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18517

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SYLVESTER Warren				2. Date of Death Month June Day 5th Year 1999		3. Time of Death 4:20am		
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA		
Funeral Director	5. Social Security Number 216-74-0925		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-17-58	9. Birthplace (State or Foreign Country) S.C.	
	Usual Residence of Decedent								
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 2503 Riggs Avenue				10f. Zip Code 21216		10g. Citizen of What Country? U. S. A			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed		16b. Kind of Business/Industry Home Improvement			
17. Father's Name (First, Middle, Last) James Warren, Sr				18. Mother's Name (First, Middle, Maiden Surname) Margie Levant					
19a. Informant's Name/Relationship (Type, Print) Gladys Warren - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Riggs Avenue Baltimore, MD 21216					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Date 6-10-99		20c. Location - City or Town, State Randallstown, MD			
21. Signature of Funeral Service Licensee Gladys Warren				22. Name and Address of Facility March F. H. West 4300 Wabash Avenue Baltimore, MD 21215					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bilateral Pneumonia Due to (or as a consequence of): b. Pulmonary tuberculosis Due to (or as a consequence of): c. Endstage Renal Disease. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 2wks		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Arran Elder MD Medical House Officer		29c. License number D38993		29d. Date signed (Month, Day, Year) 06/05/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arran Elder MD 2600 Liberty Heights Baltimore MD									
31. Date filed (Month, Day, Year) JUN 9 1999		32. Registrar's Signature B. Sparks 21215							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18518

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) DONALD WOOD				2. Date of Death Month 6 Day 3 Year 99		3. Time of Death 4:20 PM	
4a. Facility Name (If not institution, give street and number) BON SECOURS				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
5. Social Security Number 215-30-9969		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6-15-34	9. Birthplace (State or Foreign Country) MARYLAND
Usual Residence of Decedent							
10a. State MD.		10b. County		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 108 ALLENDALE ST.				10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TELLER		16b. Kind of Business/Industry NATIONS BANK	
17. Father's Name (First, Middle, Last) CHARLES WOOD				18. Mother's Name (First, Middle, Maiden Surname) EDNA WOOD			
19a. Informant's Name/Relationship (Type, Print) PATTI JACKSON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 ALLENDALE ST. BALTIMORE MARYLAND 21229			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK		Date 6-9-99		20c. Location - City or Town, State BALTIMORE MARYLAND	
21. Signature of Funeral Service Licensee Lloyd M. Estep				22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. LIVER FAILURE. Due to (or as a consequence of):</p> <p>b. HEPATIC ENCEPHALOPATHY. Due to (or as a consequence of):</p> <p>c. RENAL FAILURE. Due to (or as a consequence of):</p> <p>d.</p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Edward Obazee		29c. License number D 41430		29d. Date signed (Month, Day, Year) 06-09-1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EDWARD OBAAZEE 5309A OLDCOURT RD MD 21133							
31. Date filed (Month, Day, Year) JUN 9 1999				32. Registrar's Signature [Signature]			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18519

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAUDE A. WATSON				2. Date of Death Month Day Year May 5 1999		3. Time of Death 3:35PM	
	4a. Facility Name (If not institution, give street and number) Heartland Health Center				4b. City, Town, or Location of Death Adelphi		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-94-6622		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) July 13, 1934	
	9. Birthplace (State or Foreign Country) Jamaica, WI		10a. State District of Columbia		10b. County Washington, DC		10c. City, Town or Location Washington, DC	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 417 Shepherd St., NW		10f. Zip Code 20011		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife		16b. Kind of Business/Industry private			
	17. Father's Name (First, Middle, Last) James Walters				18. Mother's Name (First, Middle, Maiden Surname) Maude Agath Walters			
	19a. Informant's Name/Relationship (Type, Print) Donald Watson/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Shepherd St., NW Wash., DC 20011			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery		20c. Location - City or Town, State Washington, DC		20d. Date 5/11/99	
	21. Signature of Funeral Service Licensee <i>John W. Latney, Jr.</i>				22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave., NW Wash., DC 20011			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration pneumonia Due to (or as a consequence of): b. Cerebro vascular accident Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 4-6 hours							
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Tube feeding End Stage renal disease Daibetes mellitus						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Reedif</i>				29c. License number D19609		29d. Date signed (Month, Day, Year) May 7, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Raman Tuli 3503 Perry St. Suite B Mt. Rainier, MD 20712								
State Registrar	31. Date filed (Month, Day, Year) JUN 9 1999		32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten notes in a cursive script, appearing to be a list or series of entries. The text is faint and difficult to decipher, but seems to include names and possibly dates or locations. Some legible fragments include "John", "Mary", and "1840".

Handwritten signature or name, possibly "John", followed by some illegible text.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18520

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Isabella Catherine Walker					2. Date of Death Month Day Year June 7, 1999		3. Time of Death 8:01a.m.		
	4a. Facility Name (If not institution, give street and number) Augsburg Lutheran Home					4b. City, Town, or Location of Death Lochearn		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 169-50-9721		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) October 28, 1901		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
10a. State Maryland			10b. County Baltimore		10c. City, Town or Location Pikesville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 8412 Winands Road					10f. Zip Code 21208		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 th. Collega (1-4 or 5+) -					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Robert Oscar Kein, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Agnes Minerva Gashaw					
19a. Informant's Name/Relationship (Type, Print) David L. Walker (Son)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8412 Winands Road Pikesville, MD 21208					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Richland		Data June 9, 1999		20c. Location - City or Town, State Richland Township Pennsylvania			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133-4784					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC HEART DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Approximate Interval Between Onset and Death ONE MONTH										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number H45931		29d. Date signed (Month, Day, Year) JUNE EIGHTH, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah I. Pierce 2800 PARK HEIGHTS AVE BALTIMORE MD 21208										
31. Date filed (Month, Day, Year) JUN 9 1999					32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

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ARTHUR

WYNN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEMS: #16A-B PER F.H. G772 6-15-99 WR.

99 18521

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARTHUR WYNN, JR.						2. Date of Death Month Day Year JUNE 4, 1999		3. Time of Death 14:10 PM	
	4a. Facility Name (If not institution, give street and number) 1429 LIMIT AVENUE						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218 48 1084		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) 01/25/1948		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1429 LIMIT AVE.				10f. Zip Code 21239		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 68-74		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER COMPUTER ANALYST			16b. Kind of Business/Industry BALTIMORE CITY BLACK-DECKER			
17. Father's Name (First, Middle, Last) ARTHUR WYNN, SR.						18. Mother's Name (First, Middle, Maiden Surname) LAVERNE PAGE				
19a. Informant's Name/Relationship (Type, Print) LAVERNE WYNN/MOTHER						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 CHESTNUT ST. BALTO., MD. 21222				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VET CEM		20c. Date 6/9/99		20d. Location - City or Town, State OWINGS MILLS, MD.		
21. Signature of Funeral Service Licensee <i>James A. Morotn</i>						22. Name and Address of Facility JAMES A. MOROTN & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest; shock, or heart failure. List only one cause on each line. <div style="display: flex; align-items: flex-start;"> <div style="flex: 1;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Hypertensive atherosclerotic Cardiovascular disease</i></p> <p>Due to (or as a consequence of):</p> </div> <div style="flex: 1;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <i>Autoid</i> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number OCME		29d. Date signed (Month, Day, Year) JUNE 05, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JUN 9 1999		32. Registrar's Signature <i>[Signature]</i>								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18522

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Wayland				2. Date of Death Month Day Year June 1 1999				3. Time of Death 2:10pm			
	4a. Facility Name (If not institution, give street and number) Manor Care - Rossville				4b. City, Town, or Location of Death Rosedale				4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 218-12-3091		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) July 13 1924		9. Birthplace (State or Foreign Country) New York			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD.		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 5 Palm Lane				10f. Zip Code 21221		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) :		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aid				16b. Kind of Business/Industry Riverside Nursing Home					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Frederick C. Klein				18. Mother's Name (First, Middle, Maiden Surname) unknown							
	19a. Informant's Name/Relationship (Type, Print) James Messec Jr. / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 LanFlair Road Baltimore Md. 21221							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery		Data 6/4/99		20c. Location - City or Town, State Baltimore Md.					
	21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Electrolyte imbalance</u> Due to (or as a consequence of): b. <u>Dehydration</u> Due to (or as a consequence of): c. <u>Mental Status Changes</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death a. <u>one wk</u> b. <u>2 wks</u> c. <u>2-3 wks</u> d. 	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Seizure disorder</u> <u>Type II DM</u>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29b. Signature and title of certifier Malika Wassem M.D.				29c. License number D-38754		29d. Date signed (Month, Day, Year) 06-01-99					
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALIKA WASSEM, 404 EASTERN BLVD, M.D - 21221											
	31. Date filed (Month, Day, Year) JUN 9 1999		32. Registrar's Signature S. Sparks									

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18523

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>William white</i>				2. Date of Death Month Day Year <i>June 02 1999</i>		3. Time of Death <i>9:31am</i>	
	4a. Facility Name (If not institution, give street and number) <i>East Point Nursing Home</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>218-01-8240</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>108</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Oct. 5, 1890</i>	
	9. Birthplace (State or Foreign Country) <i>unknown</i>		10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Baltimore</i>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <i>1046 Old Northpoint Road</i>				10f. Zip Code <i>21224</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>none</i> College (1-4 or 5+) <i>none</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i>		16b. Kind of Business/Industry <i>Railroad</i>			
	17. Father's Name (First, Middle, Last) <i>unknown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>unknown</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Eastpoint Nursing Home</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1046 Old Northpoint Road, Baltimore, MD 21224</i>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>				22. Name and Address of Facility <i>State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dehydration with electrolyte imbalance</i>							
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) <i>a. Arteriosclerotic Heart Disease</i>				Due to (or as a consequence of): <i>Arteriosclerosis</i>			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Due to (or as a consequence of):			
					Due to (or as a consequence of):			
					Due to (or as a consequence of):			
					Due to (or as a consequence of):			
					Due to (or as a consequence of):			
					Due to (or as a consequence of):			
					Due to (or as a consequence of):			
					Due to (or as a consequence of):			
					Due to (or as a consequence of):			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Ronald S. Wade</i>				29c. License number <i>011150</i>		29d. Date signed (Month, Day, Year) <i>6/2/99</i>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MELITO M. TORRES MD 441 S. ELLWOOD AVE, BALTO, MD 21224</i>							
	31. Date filed (Month, Day, Year) <i>JUN 08 1999</i>				32. Registrar's Signature <i>B. Sparks</i>			
	State Registrar							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND ITEM #1 PER PHYNS G772 6-10-99 J.A.

99 18524

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ALISA Adams

2. Date of Death
Month Day Year

June 06 1999

3. Time of Death

1:43

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

212-90-9701

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

34

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Sept. 8, 1964

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1616 Riverwood Road

10f. Zip Code

21221

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
7 Years

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Bill Adams

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Gibson

19a. Informant's Name/Relationship (Type, Print)

Mary Friend/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 Villa Capri Circle Essex, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gdns. 6/9/99

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HIV / AIDS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Claudia Claiborne MD

29c. License number

96764

29d. Date signed (Month, Day, Year)

June 06, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Claudia Claiborne 4940 Eastern Ave Baltimore, MD

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AS201 20

[Faint, mostly illegible text and markings covering the page, including some handwritten notes and possibly a signature in the center.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18525

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) <u>Milton P. Boguski</u>				2. Date of Death Month <u>June</u> Day <u>7</u> Year <u>1999</u>		3. Time of Death <u>1:45 pm</u>	
4a. Facility Name (If not institution, give street and number) <u>1A#2 Center Rd</u>				4b. City, Town, or Location of Death <u>Towson</u>		4c. County of Death <u>Baltimore</u>	
5. Social Security Number <u>218-05-7811</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>79</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>May 28 1920</u>	
9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Md</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Towson</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>1A#2 Center Rd</u>		10f. Zip Code <u>21286</u>		10g. Citizen of What Country? <u>USA</u>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>-</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Composition Room</u>		16b. Kind of Business/Industry <u>Baltimore Sunpaper</u>		17. Father's Name (First, Middle, Last) <u>Paul Boguski</u>	
18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret Anderson</u>		19a. Informant's Name/Relationship (Type, Print) <u>Susan L. Patterson</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9025 Peeping Park Rd Baltimore, Md 21234</u>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Evans Funeral Chapel - Bel Air</u>		20c. Date <u>June 8</u>		20d. Location - City or Town, State <u>Forest Hill, Md</u>		21. Signature of Funeral Service Licensee <u>Keita J. Wells</u>	
22. Name and Address of Facility <u>EVANS Funeral Chapel</u>		22a. Address <u>8800 Harford Rd. Baltimore, Md 21234</u>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>Ventricular Fibrillation</u> Due to (or as a consequence of): b. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death <u>minutes</u> <u>10 years</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimer's Disease</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier <u>Dr. Thomas Wilson MD</u>		29c. License number <u>D40277</u>		29d. Date signed (Month, Day, Year) <u>June 8, 1999</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Thomas Wilson Good Samaritan Hos. Russell Morgan Bldg Suite 502</u>	
31. Date filed (Month, Day, Year) <u>JUN 10 1999</u>		32. Registrar's Signature <u>[Signature]</u>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18526

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN R BRADY				2. Date of Death Month Day Year JUNE 6 1999		3. Time of Death 6:55 AM	
	4a. Facility Name (If not institution, give street and number) 5316 BANGERT STREET				4b. City, Town, or Location of Death WHITE MARSH		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 196-22-5493		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) JAN 20, 1930	
	9. Birthplace (State or Foreign Country) PA		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location WHITE MARSH	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 5316 BANGERT STREET		10f. Zip Code 21162		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) +2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TAX PREPARATION		16b. Kind of Business/Industry SELF EMPLOYED			
	17. Father's Name (First, Middle, Last) Ignatius Yuchnis				18. Mother's Name (First, Middle, Maiden Surname) Mary Yuracavch			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ed Brady				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5316 Bangert St. White Marsh, Md 21162			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EVANS FUNERAL CHAPEL BELAIR - P.A.		20c. Location - City or Town, State FOREST HILL, MD		20d. Date June 9 1999	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 HARFORD RD. PARKVILLE, MD. 21234			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Left Lung Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 years							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>[Signature]</i> Staff physician				29c. License number 019714		29d. Date signed (Month, Day, Year) 6/8/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL FURRI, JR. 4940 EATON AVE BALTIMORE, MD 21224							
State Registrar	31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature <i>[Signature]</i>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18527

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AUREY MARY BIGGERMAN				2. Date of Death Month Day Year June 4 1999		3. Time of Death 6:00 PM	
	4a. Facility Name (If not institution, give street and number) 2011 EXPRESS DRIVE				4b. City, Town, or Location of Death BLAIR		4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 216-14-7969	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year) Nov. 2, 1914	9. Birthplace (State or Foreign Country) Washington D.C.			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County HARFORD	10c. City, Town or Location BLAIR		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 2011 EXPRESS DRIVE		10f. Zip Code 21015		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 YRS College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry AT HOME			
	17. Father's Name (First, Middle, Last) SILAS W. KEYS				18. Mother's Name (First, Middle, Maiden Surname) FANNIE M. SHIFFLET			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) RITA V. SAXON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4037 MADONNA ROAD JARRETTVILLE MARYLAND 21084			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BLAIR MEMORIAL GARDENS		20c. Location - City or Town, State BLAIR MARYLAND		20d. Date JUNE 7 1999	
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility EVANS FUNERAL CHAPEL - BLAIR, P.A. 21050 30 NEWPORT DRIVE FOREST HILL MARYLAND			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Thoracic Aortic Aneurysm Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number D35012		29d. Date signed (Month, Day, Year) JUNE 7, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Kevin Lynch MD 2 North Ave. Blair, Md. 21014								
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18528

ITEM#23a&23b PER PHYNS G772 6-10-99 J.A.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Francis Joseph Blair				2. Date of Death Month Day Year May 17 1999		3. Time of Death 6:30 A.M.		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 214-14-5891	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 19 1914		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Md.		10b. County Anne Arundel		10c. City, Town or Location Annapolis		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1541 Shipsvie Road				10f. Zip Code 21401		10g. Citizen of What Country? U.S.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney		16b. Kind of Business/Industry Legal			
17. Father's Name (First, Middle, Last) Francis Clemens Blair				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth McKenna					
19a. Informant's Name/Relationship (Type, Print) Kathleen T. Blair/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1541 Shipsvie Rd. Annapolis Md. 21401					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cem.		20c. Location - City or Town, State 5/20 Baltimore, Md.					
21. Signature of Funeral Service Licensee <i>George J. Gonce</i>				22. Name and Address of Facility George J. Gonce F.H. P.A. 4001 Ritchie Hwy. Balto. Md. 21225					
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Respiratory</i> PNEUMONIA Due to (or as a consequence of): b. <i>Respiratory</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Dr. Wernick MD</i>				29c. License number D38445		29d. Date signed (Month, Day, Year) May 17, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Wernick 600 N. Gay Ave #121 Annapolis MD									
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature <i>Barbara B. Sparks</i>							

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

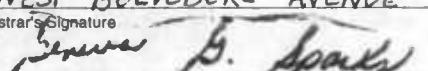
Handwritten text at the bottom of the page, possibly a signature or date, and the printed text "JUN 1 1960".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

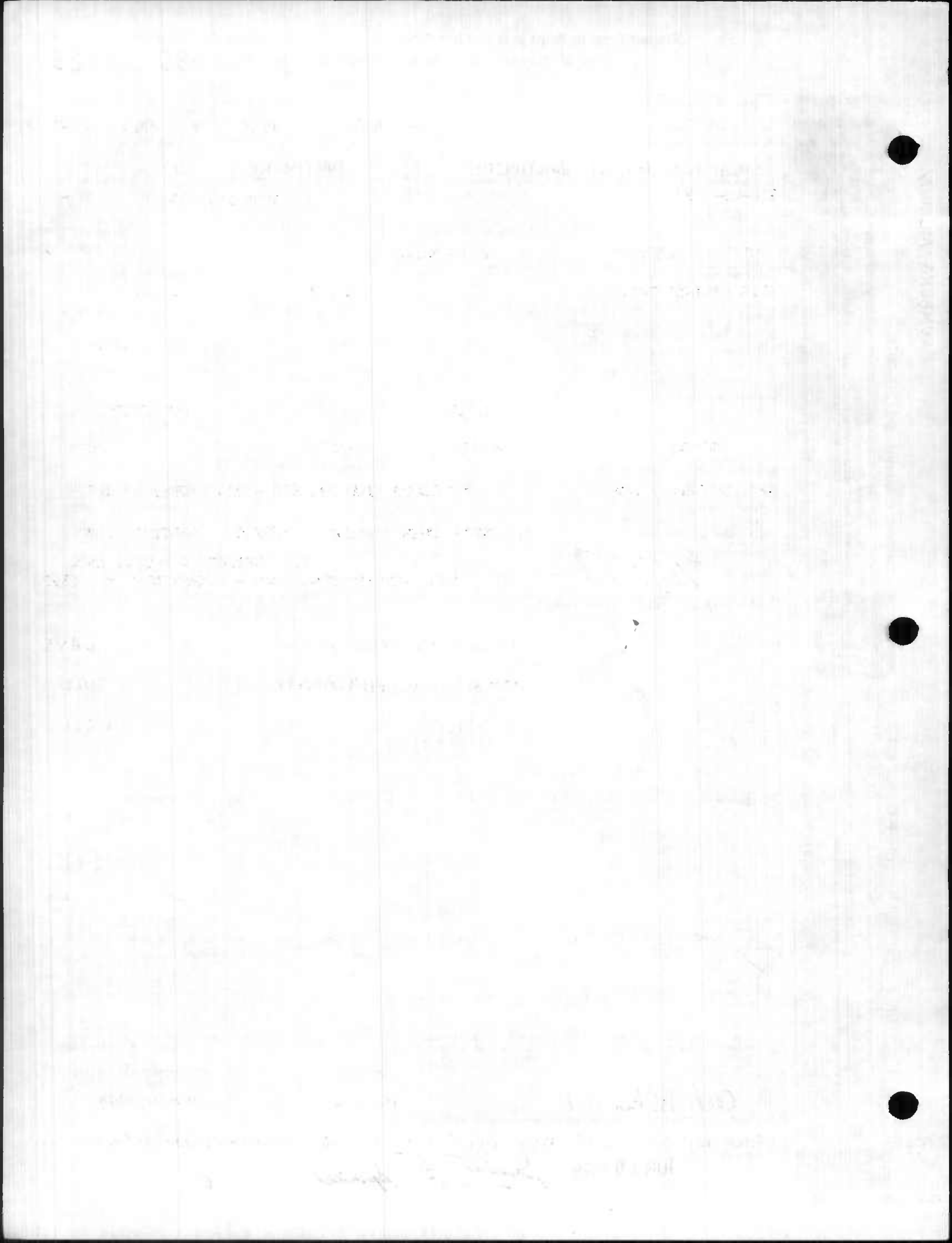
State of Maryland / Department of Health and Mental Hygiene 99 18529

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVIN BLUMBERG				2. Date of Death Month Day Year JUNE 4 1999		3. Time of Death 2:25 PM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-03-4582		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 22, 1920	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location OWINGS MILLS	
Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 2316 MELINDA DRIVE				10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) C.P.A.		16b. Kind of Business/Industry ACCOUNTING		
17. Father's Name (First, Middle, Last) NATHAN BLUMBERG				18. Mother's Name (First, Middle, Maiden Surname) ESTHER SHOR				
19a. Informant's Name/Relationship (Type, Print) MAX BLUMBERG / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6907 JONES VIEW DR. #3B - BALTIMORE, MD 21209				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO		Date 6/7/99		20c. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY EMBOLUS Due to (or as a consequence of): b. ANOXIC ENCEPHALOPATY Due to (or as a consequence of): c. SEPSIS Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death DAYS DAYS WEEKS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  Carla Watson, M.D.		29c. License number P12344		29d. Date signed (Month, Day, Year) JUNE 4, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARLA WATSON 2401 WEST BELVEDERE AVENUE BALTIMORE, MARYLAND 21215								
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 						

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18530

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELLEN F BLOOM		2. Date of Death Month Day Year JUNE 7, 1999		3. Time of Death 2:10 PM
	4a. Facility Name (If not institution, give street and number) NORTH OAKS HEALTH CENTER		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 579-42-5239	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month Day Year JULY 17, 1908		9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent					
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
10e. Street and Number 725 MT. WILSON LANE		10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER		16b. Kind of Business/Industry NURSERY SCHOOL	
17. Father's Name (First, Middle, Last) SIMON FRANK			18. Mother's Name (First, Middle, Maiden Surname) ROSE ELLEN HECHT		
19a. Informant's Name/Relationship (Type, Print) JULIAN S. STEIN/ BROTHER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 HOFF ROAD UNION BRIDGE, MD. 21791		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HILLTOP SERVICE CORP.		20c. Location - City or Town, State 6/8/99 TOWSON, MD	
21. Signature of Funeral Service Licensed			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Obstructive lung disease Chronic atrial fibrillation					Approximate Interval Between Onset and Death 6 weeks 10 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive lung disease Chronic atrial fibrillation					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature] MD		29c. License number D38675		29d. Date signed (Month, Day, Year) 6/7/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL MESHULAM 1147 S HANOVER ST BALTIMORE MD 21230					
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature [Signature]			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18531

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOLORES E. BURGER				2. Date of Death Month 6 Day 7 Year 99		3. Time of Death 5:40 PM	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL/TRAUMA				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-20-1160		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 15, 1926	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Upperco			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 15915 Trenton Rd.				10f. Zip Code 21155		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Manufacturing	
17. Father's Name (First, Middle, Last) Joseph Staub					18. Mother's Name (First, Middle, Maiden Surname) Verna Brennan			
19a. Informant's Name/Relationship (Type, Print) George E. Burger Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15915 Trenton Rd., Upperco, MD 21155				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem.		20c. Location - City or Town, State 6/11/99 Owings Mills, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. INFARCTED BOWEL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RESPIRATORY FAILURE RENAL FAILURE NECROTIZING FASCITIS						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Cynthia M. Soriano MD		29c. License number 00051347		29d. Date signed (Month, Day, Year) 6/7/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA M. SORIANO, MD UMMS 22 S. Greene Street, Baltimore, MD 21201								
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social development.

4. The fourth part of the report deals with the political situation of the country. It is a very interesting and informative study of the country's political development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's political development.

5. The fifth part of the report deals with the cultural situation of the country. It is a very interesting and informative study of the country's cultural development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's cultural development.

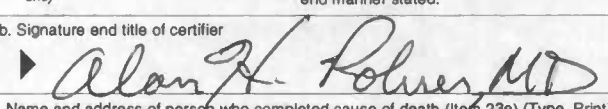
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18532

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jessica Maureen CHABOT				2. Date of Death Month Day Year May 31, 1999		3. Time of Death 3:56 pm				
	4a. Facility Name (If not Institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick				
Funeral Director	5. Social Security Number 026-62-3518		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 22 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 8, 1977		9. Birthplace (State or Foreign Country) North Carolina		
	Usual Residence of Decedent										
10a. State Virginia		10b. County Fairfax		10c. City, Town or Location Burke				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 10622 Alison Drive				10f. Zip Code 22015		10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Caucasian			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Substitute Teacher			16b. Kind of Business/Industry Fairfax County Schools				
17. Father's Name (First, Middle, Last) Guy A. Chabot					18. Mother's Name (First, Middle, Maiden Surname) Patricia M. Bergeron						
19a. Informant's Name/Relationship (Type, Print) Guy Chabot, father					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10622 Alison Drive, Burke, VA 22015						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Fairfax Crematory		Date 6/5/99		20c. Location - City or Town, State Fairfax, VA				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Everly Funeral Home 10565 Main Street, Fairfax, VA 22030						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Multiple Traumatic Injuries Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death Immediate	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) May 31, 1999		28b. Time of Injury 3:15pm M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Passenger in Vehicle Collision		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Interstate Highway				28f. Location (Street and Number or Rural Route Number, City or Town, State) Rte 270 N/B @26 mile marker, Frederick, MD				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier  Alan H. Rohrer, M.D.			29c. License number D37197		29d. Date signed (Month, Day, Year) June 01, 1999			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Alan H. Rohrer, M.D., 1080 West Patrick Street, Frederick, Maryland 21703											
31. Date filed (Month, Day, Year) JUN 10 1999			32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Henry Coleman				2. DATE OF DEATH MONTH April DAY 28 YEAR 1999				3. TIME OF DEATH 8:30 A M		
4. SOCIAL SECURITY NUMBER 231-26-8319		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (in yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 28, 1928		8. BIRTHPLACE (State or Foreign Country) Virginia		
9a. FACILITY NAME (If not institution, give street and number) Citizen's Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick		
RESIDENCE OF DECEDENT										
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Libertytown				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 12102 Main St.				10f. ZIP CODE 21762		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) carpenter			16b. KIND OF BUSINESS/INDUSTRY home improvement			
17. FATHER'S NAME (First, Middle, Last) George Carter Coleman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helena						
19a. INFORMANT'S NAME (Type/Print) Dean Perkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12102 Main St. Libertytown, MD 21762						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chapel Cemetery		DATE 4/30		20c. LOCATION — City or Town, State nr. Libertytown, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Catharine O. Harder				22. NAME AND ADDRESS OF FACILITY Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>End stage renal failure</u> DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Congestive heart failure</u> END STAGE RENAL FAILURE									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Ali S. Harkat MD				29c. LICENSE NUMBER D35183		29d. DATE SIGNED (Month, Day, Year) 4/28/99				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ali S. Harkat MD 300 W 9th St Frederick MD 21701										
31. DATE FILED (Month, Day, Year) MAY 03 1999				32. REGISTRAR'S SIGNATURE B. Sparks						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18534

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARJORIE

CASSEL

2. Date of Death

JUNE 5, 1999

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

CHERRYWOOD NURSING HOME

4b. City, Town, or Location of Death

REISTERSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-20-5031

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 1, 1928

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7070 CRADLEROCK WAY

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

2 Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADVERTISING DIRECTOR

16b. Kind of Business/Industry

BALTIMORE SYMPHONY ORCHE

17. Father's Name (First, Middle, Last)

JACOB

18. Mother's Name (First, Middle, Maiden Surname)

WOLOD

IDA

SHINE

19a. Informant's Name/Relationship (Type, Print)

MARC CASSEL / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3750 ASHLEY WAY - OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHEVRA AHAVAS CHESED

Date

6/7/99

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. pancreatic cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P15872

29d. Date signed (Month, Day, Year)

June 7 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOROLD B. BIR 25 MARIE ST 21136 REISTERSTOWN

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

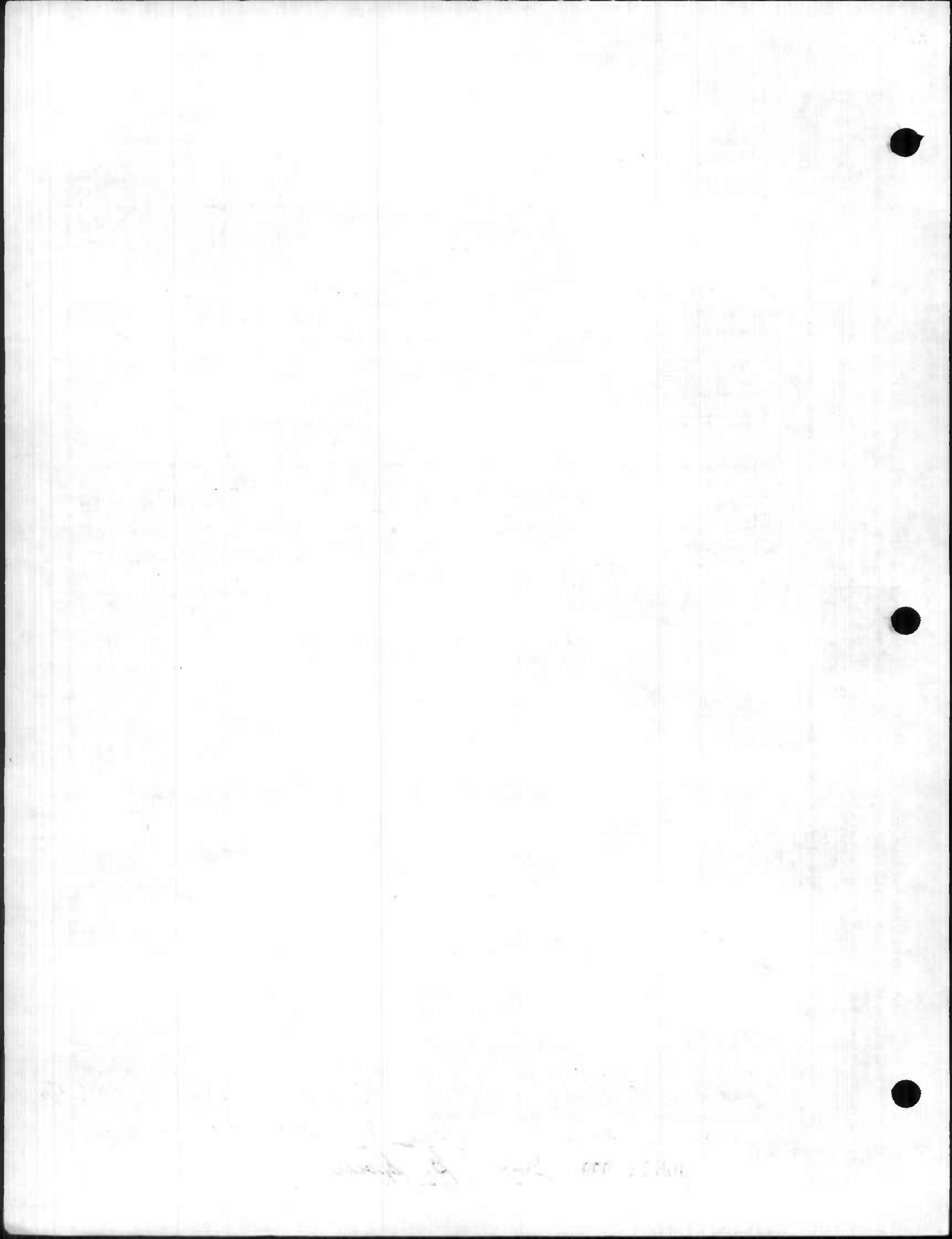
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18535

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NATHANIEL M COHEN				2. Date of Death Month Day Year JUNE 6, 1999		3. Time of Death 5:40 PM	
	4a. Facility Name (If not institution, give street and number) 2810 DAMASCUS COURT #F				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-20-8272	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 26, 1928		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2810 DAMASCUS COURT #F			10f. Zip Code 21209		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES			16b. Kind of Business/Industry HOME IMPROVEMENT		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) IRVIN COHEN				18. Mother's Name (First, Middle, Maiden Surname) IDA BALSER			
	19a. Informant's Name/Relationship (Type, Print) PAULINE COHEN / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2810 DAMASCUS COURT #F - BALTIMORE, MD 21209			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS CEMETERY		Date 6/8/99		20c. Location - City or Town, State OWINGS MILLS, MD	
	21. Signature of Funeral Service Licensee <i>Scott M. Cuthbert</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End Stage renal disease Due to (or as a consequence of): b. Diabetes Mellitus Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death years years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive Heart Disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier H. Friedman MD				29c. License number D01703		29d. Date signed (Month, Day, Year) June 7, 1999	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Friedman MD 23 Crossroads Drive Owings Mills, MD 21117							
	31. Date filed (Month, Day, Year) JUN 10 1999				32. Registrar's Signature <i>G. Sparks</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18536

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARICE

RENEE

COUNTS

2. Date of Death

JUNE 4, 1999

3. Time of Death

6:15 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6402 GUILFORD ROAD

4b. City, Town, or Location of Death

CLARKSVILLE

4c. County of Death

HOWARD

5. Social Security Number

215-24-3330

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 8, 1923

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

CLARKSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

6402 GUILFORD ROAD

10f. Zip Code

21029

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SPEECH LANGUAGE PATHOLOGIST

16b. Kind of Business/Industry

HEALTH

17. Father's Name (First, Middle, Last)

NATHAN

GLICKMAN

18. Mother's Name (First, Middle, Maiden Surname)

ROSIE

LEVIN

19a. Informant's Name/Relationship (Type, Print)

ALFRED B. COUNTS / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6402 GUILFORD ROAD - CLARKSVILLE, MD 21029

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

AGUDAS ACHIM ANSHE SFARD

AHAVAS SHABOM

6/6/99

20c. Location - City or Town, State

ROSEDALE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a.

Cancer of Colon with metastasis

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D22110

29d. Date signed (Month, Day, Year)

6/4/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARC A. KARLA MD 2845 OAKWOOD ROAD

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

2106

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

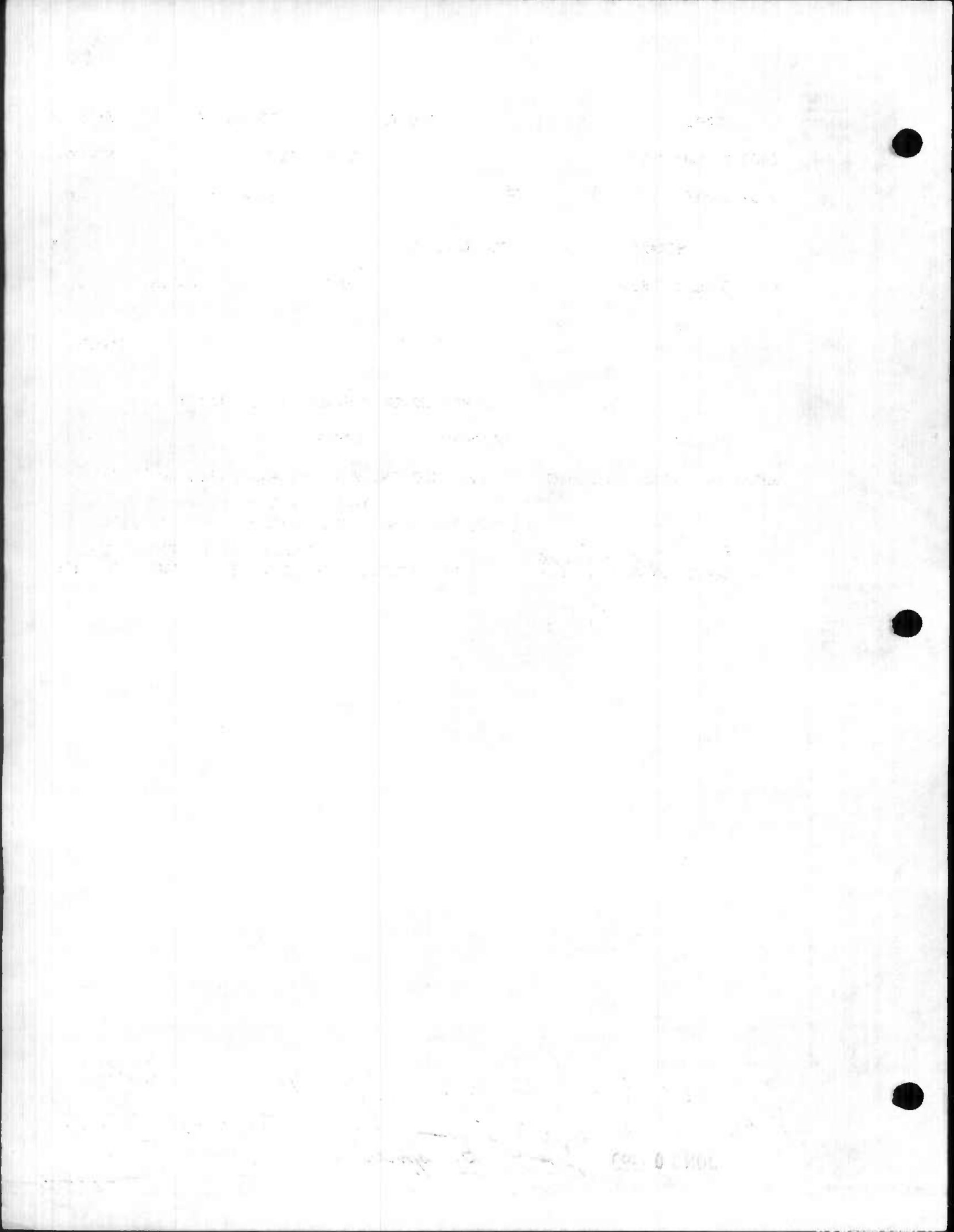
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18537

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARI

CHECKANOW

2. Date of Death

Month

Day

Year

June

4

1999

3. Time of Death

4:46 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

217-66-8585

6. Sex

M

20 F

7. Age (In yrs. last birthday)

34 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month, Day, Year

JULY 19, 1964

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3110 BONNIE ROAD

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

2 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

YEHUDAH

CHECKANOW

18. Mother's Name (First, Middle, Maiden Surname)

JOYCE

HAWTOF

19a. Informant's Name/Relationship (Type, Print)

JOYCE HAWTOF / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4508 15TH AVE. - BROOKLYN, NY 11219

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TZEMECH ZEDEK CEMETERY

Date

6/4/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKEVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. pneumonia Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bipolar disorder

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

5 Pending investigation

2 Accident

6 Could not be determined

3 Suicide

4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Wiedersheim M.D.

29c. License number

P12345

29d. Date signed (Month, Day, Year)

June 4th, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Wiedersheim

Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ARI CHECKANOW
Baltimore, Maryland 21215-0020

pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18538

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARJORIEMAE LOUISE CARSON				2. Date of Death Month Day Year JUNE 3, 1999		3. Time of Death 7:45 P.M.	
	4a. Facility Name (If not institution, give street and number) 2669 ST. BENEDICT STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-30-2586		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 6, 1935	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) FREDERICK, MD		10. State MARYLAND		10b. County N/A	
To Be Completed by Funeral Director	10a. State		10b. County		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 2669 ST. BENEDICT STREET				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th GRADE College (14 or 5+) College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLEANING		16b. Kind of Business/Industry CLEANING COMPANY			
	17. Father's Name (First, Middle, Last) HOWARD VIRTIS				18. Mother's Name (First, Middle, Maiden Surname) DOROTHY JACKSON			
	19a. Informant's Name/Relationship (Type, Print) GINGER A. CLARK (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2669 ST. BENEDICT STREET-BALTIMORE, MARYLAND 21223			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		20c. Date 6/7/99		20d. Location - City or Town, State BALTIMORE, MARYLAND	
	21. Signature of Funeral Service Licensee <i>Guanta R. Thomas</i>				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PANCREATIC CANCER - METASTATIC Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) N/A		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) N/A		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Thistair E. Ege</i>				29c. License number D46071		29d. Date signed (Month, Day, Year) 6/7/99		
30. Name and address of person who completed certificate of death (Item 23a) (Type, Print) DR. ALISTAIR ESEGE - 2447 WEST FREDERICK ROAD - BALTIMORE, MARYLAND 21223								
31. Date filed (Month, Day, Year) JUN 10 1999				32. Registrar's Signature <i>B. Sparks</i>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18539

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Thelma D. DeMarino</u>				2. Date of Death Month <u>June</u> Day <u>9</u> Year <u>1999</u>		3. Time of Death <u>6:55am</u>	
	4e. Facility Name (If not institution, give street and number) <u>Franklin Square Hospital center</u>				4b. City, Town, or Location of Death <u>Rosedale</u>		4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>515-18-6270</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>72</u> Yrs.	If Under 1 Year Months <u> </u> Days <u> </u>	If Under 24 Hrs. Hours <u> </u> Min. <u> </u>	8. Date of Birth (Month, Day, Year) <u>JUNE 15 1926</u>		9. Birthplace (State or Foreign Country) <u>Kansas</u>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <u>Md</u>	10b. County <u>Baltimore</u>	10c. City, Town or Location <u>Parkville</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <u>2808 Somat Ave.</u>			10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>USA</u>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Contract Specialist</u>		16b. Kind of Business/Industry <u>Federal Government</u>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>Roy Duffey</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Katherine Wrescoll</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>Caemen A. DeMarino</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2808 Somat Ave. Baltimore, Md 21234</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Gardens of Faith Come.</u>		20c. Location - City or Town, State <u>Rosedale, Maryland</u>		20d. Date <u>June 12 1999</u>	
	21. Signature of Funeral Service Licensee <u>Keith S. Wells</u>		22. Name and Address of Facility <u>Evans Funeral Chapel</u> <u>8800 Harford Rd Baltimore, Md 21234</u>					
Physician /Medical Examiner	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Metastatic Lung Cancer</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <u>6 months</u>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Atrial Fibrillation, Stroke, Hypertension</u>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier <u>Pedro Amador MD</u>		29c. License number <u>RD 186478</u>		29d. Date signed (Month, Day, Year) <u>June 9 1999</u>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>D. Pedro Amador 9000 Franklin Square Drive Baltimore, MD 21237</u>							
	31. Date filed (Month, Day, Year) <u>JUN 10 1999</u>		32. Registrar's Signature <u>[Signature]</u>					

Barbers of Park Cove. 1999
Evan's Funeral Chapel
8800 Hartford Rd. Baltimore, MD 21234

F. Wells

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18540

ITEM: #23 PART I, PER MD G772 6-10-99 WR.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WAYNE DEWITT				2. Date of Death Month JUNE Day 4 Year 1999		3. Time of Death 04:50PM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
Funeral Director	5. Social Security Number 145-62-3250	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08-19-67	9. Birthplace (State or Foreign Country) NJ	
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Glen Burnie		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 8040 Montague Court				10f. Zip Code 21061		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Severn-Chimney Construction Co.		
17. Father's Name (First, Middle, Last) Homer Denson				18. Mother's Name (First, Middle, Maiden Surname) Betty DeWitt				
19a. Informant's Name/Relationship (Type, Print) Betty DeWitt				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 East Front Street Trenton, N.J. 08611 Apt. #807				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ewing Cemetery 06-12-99 Ewing Township, N.J.		20c. Location - City or Town, State		20d. Location - City or Town, State		
21. Signature of Funeral Service Licensee Bernard D. Johnson				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. END-STAGE LIVER DISEASE hepatic failure Due to (or as a consequence of): alcohol abuse Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 years								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier J. W. Winakor MD PHYSICIAN				29c. License number RES-000		29d. Date signed (Month, Day, Year) JUNE 4, 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SHANNON J. WINAKOR, MD JOHNS HOPKINS HOSPITAL, 600 N. WOLFE STREET, BALTIMORE, MARYLAND 21287								
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature Shirley B. Sparks						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18541

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Orante D'Amico

2. Date of Death

Month
JuneDay
06Year
1999

3. Time of Death

12:00 Noon

4a. Facility Name (If not institution, give street and number)

Church Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

214-44-5162

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
1-09-1913

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3709 Claremont Street

10f. Zip Code

21224

10g. Citizen of What Country?

Italy

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5th

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Trackman

16b. Kind of Business/Industry

R. Canton Railroad

17. Father's Name (First, Middle, Last)

Rocco D'Amico

18. Mother's Name (First, Middle, Maiden Surname)

Maria Barile

19a. Informant's Name/Relationship (Type, Print)

Perla D'Amico

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3709 Claremont St., Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oaklawn Cemetery

Date

6/10/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Maria B. Zannino

22. Name and Address of Facility

Joseph N. Zannino Jr. Funeral Hm
263 S. Conkling St., Baltimore, Maryland 2122423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. GRAM POSITIVE SEPSIS

Approximate
Interval Between
Onset and Death

3 days

Due to (or as a consequence of):

b. BILATERAL PNEUMONIA

1 wk

Due to (or as a consequence of):

c. (R) HIP FRACTURE

2 wk

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

NOTE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)
MAY 23 199928b. Time of
Injury

100 PM

28c. Injury at
Work?1 ☐ Yes 2 ☒ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

AT HOME

28d. Describe how injury occurred
FALL AT HOME ATTEMPTING
TO REACH FOR WALKER28f. Location (Street and Number or Rural Route Number,
City or Town, State)

3709 CLAREMONT

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul T. Barbera MD

29c. License number

D 37708

29d. Date signed (Month, Day, Year)

JUNE 08 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL T BARBERA MD 3700 CLAREMONT ST.

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

Barbara B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

99 18542

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Martha Madelyn Disney</u>				2. Date of Death Month <u>June</u> Day <u>9</u> Year <u>1999</u>		3. Time of Death <u>8:05 PM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Hamilton - Genesis Nursing Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>205-12-9638</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>90</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>July 29, 1908</u>	
	9. Birthplace (State or Foreign Country) <u>Pennsylvania</u>		10a. State <u>Maryland</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>3019 Chesterfield Avenue</u>		10f. Zip Code <u>21213</u>		10g. Citizen of What Country? <u>U. S. A.</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8th Grade</u> College (1-4 or 5+) <u>College</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Machinist</u>		16b. Kind of Business/Industry <u>Kopper's Piston Rings</u>				
17. Father's Name (First, Middle, Last) <u>Frank Gricoski</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Unknown</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Cecelia A. Wallace (Daughter)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3019 Chesterfield Ave., Baltimore, Maryland 21213</u>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Green Mount Crematory</u>		20c. Location - City or Town, State <u>Baltimore, Maryland</u>				
21. Signature of Funeral Service Licensee <u>Bruce C. Wallace</u>				22. Name and Address of Facility <u>Schimunek Funeral Home Inc.</u> <u>3331 Brehms Lane, Baltimore, Maryland 21213</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Pneumonia</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D45475</u>		
29d. Date signed (Month, Day, Year) <u>6/10/99</u>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Mohammad Rahnama, 17 Fontana Lane, Suite 105, Baltimore, Maryland 21237</u>				
31. Date filed (Month, Day, Year) <u>JUN 10 1999</u>				32. Registrar's Signature <u>[Signature]</u>				

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18543

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary M. Dailey				2. Date of Death Month Day Year June 05 1999				3. Time of Death 11:50 P.M.			
	4a. Facility Name (If not institution, give street and number) St. Agnes Nursing Center				4b. City, Town, or Location of Death Ellicott City				4c. County of Death Howard			
Funeral Director	5. Social Security Number 213-24-5466	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	8. Date of Birth (Month, Day, Year) June 23, 1905	9. Birthplace (State or Foreign Country) West Virginia							
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Md.	10b. County Howard	10c. City, Town or Location Ellicott City				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 3000 N. Ridge Rd.			10f. Zip Code 21043			10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Dept. Stores					
	17. Father's Name (First, Middle, Last) Alphonse Christ				18. Mother's Name (First, Middle, Maiden Surname) Johanne Goheen							
	19a. Informant's Name/Relationship (Type, Print) Mary Regina Yeager				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Maiden Choice Lane Apt. 8T04 Catonsville, Md. 21228							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National Cem.		Date June 8, 1999		20c. Location - City or Town, State Balto. Md.					
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Rd. Pasadena, Md. 21122							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of): b. <u>DISEASE</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 3 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier [Signature]		
29c. License number 145931										29d. Date signed (Month, Day, Year) JUNE SEVENTH 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Deborah I. Pierce, 7220 Park Heights Avenue Balto., Md. 21208												
31. Date filed (Month, Day, Year) JUN 10 1999										32. Registrar's Signature [Signature]		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AD 6

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State of Maryland / Department of Health and Mental Hygiene

99 18544

ITEM: #19A PER F.H. G776 6-10-99 WR.

Certificate of Death

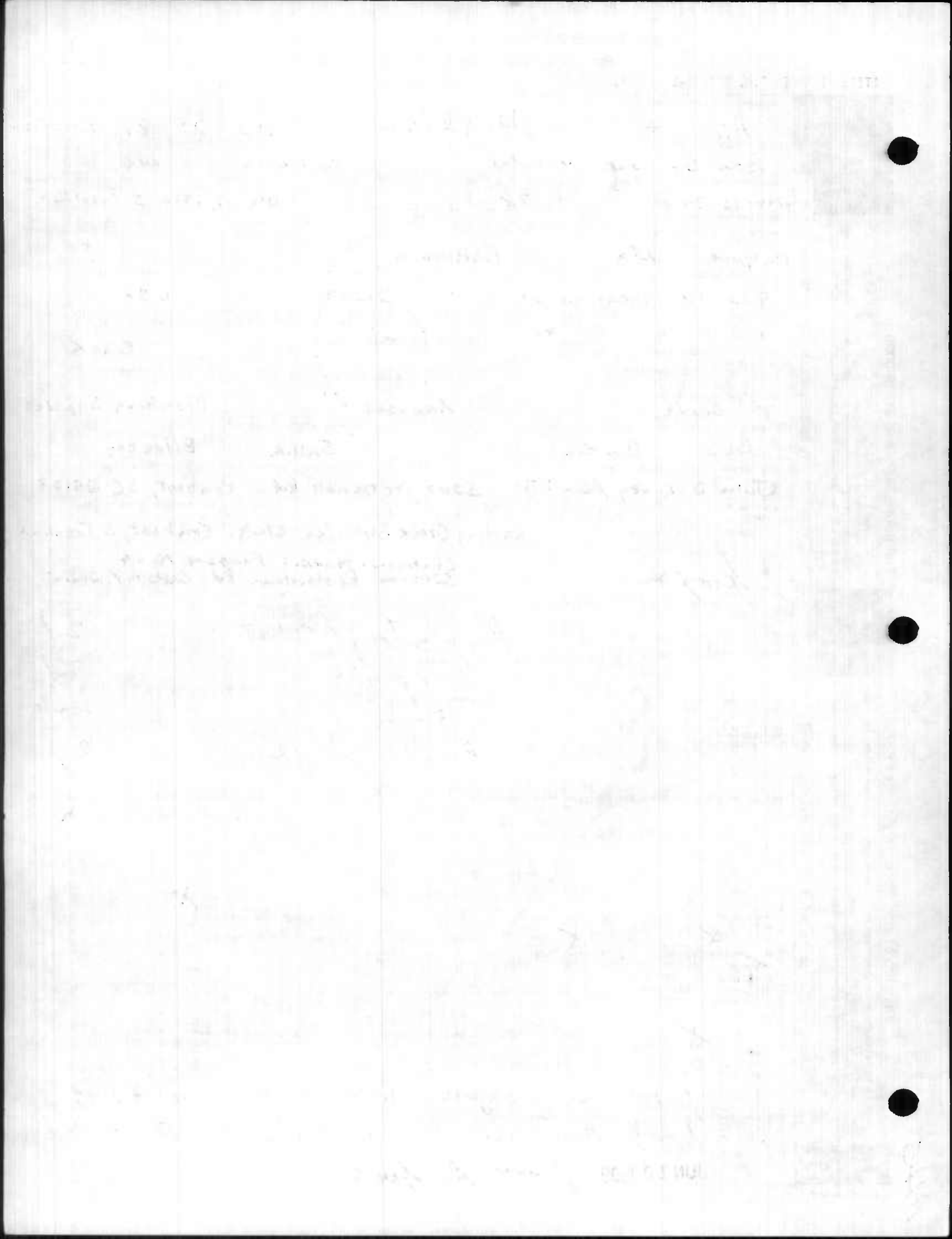
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albert Dinkins				2. Date of Death Month 06 Day 08 Year 99		3. Time of Death 5:00pm	
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 248-32-3417		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Dec 23, 1920	
	9. Birthplace (State or Foreign Country) S. CAROLINA		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BAHIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 922 W. SARATOGA ST			
	10f. Zip Code 21223				10g. Citizen of What Country? USA			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) 3rd Grade		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry Plumbing Supplies			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) BEN DINKINS				18. Mother's Name (First, Middle, Maiden Surname) SALLIE ELLEBAY			
	19a. Informant's Name/Relationship (Type, Print) Julia D. honey / SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5307 McDAVIDS Rd. Rembert, SC 29128			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RAFTING CREEK BAPTIST CH.		20c. Date 6/12/99		20d. Location - City or Town, State Rembert, S. CAROLINA	
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Chatman - HARRIS FUNERAL HOME 5240 - 44 Reisterstown Rd. Balto. Md. 21215					
To Be Completed by Physician/Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory arrest Sepsis Stroke Renal failure							Approximate Interval Between Onset and Death 2d 5d 2wk 2yr.
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier [Signature]
To Be Completed by Physician/Medical Examiner	29c. License number D29769		29d. Date signed (Month, Day, Year) 6/8/99					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARCELIN D. ROBERTSON 1120 W. Rolling Rd Balto. Md							
State Registrar	31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AHS

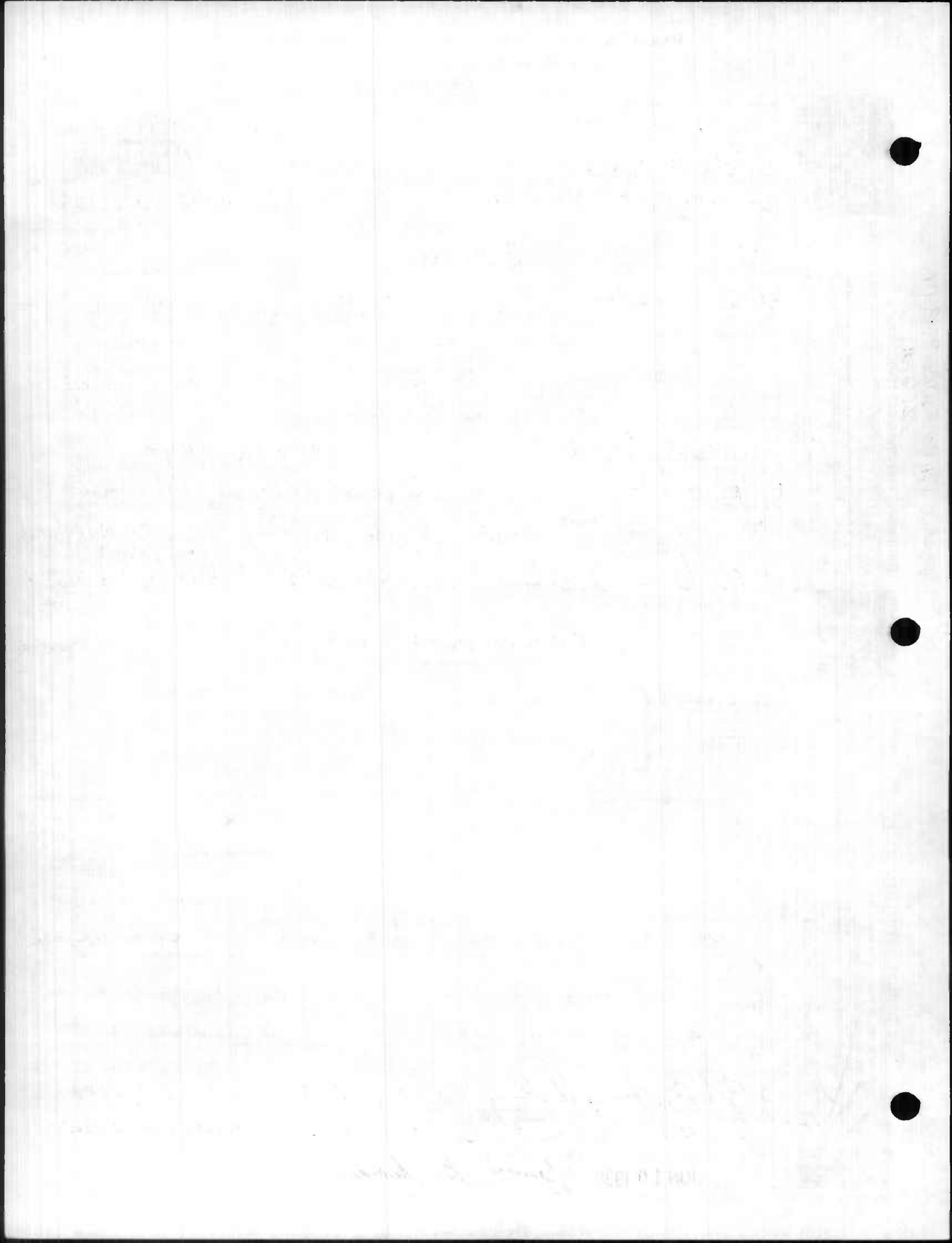


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 18546**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald W. Eyler				2. Date of Death Month June Day 8 Year 1999				3. Time of Death 2:56AM		
	4a. Facility Name (If not institution, give street and number) Bilcheist Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-07-1774		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 11, 1912		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Md		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 4423 Raspe Ave.				10f. Zip Code 21206				10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BRICK MASON				16b. Kind of Business/Industry concrete finisher contractor				
	17. Father's Name (First, Middle, Last) Archibald Eyler				18. Mother's Name (First, Middle, Maiden Surname) unknown Delphy						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Patricia Nemec				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4423 Raspe Ave. Baltimore, Md 21206						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Come.		Date June 11 1999		20c. Location - City or Town, State Rosedale, Maryland				
	21. Signature of Funeral Service Licensee Krista S. Wells				22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234						
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of the tongue Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 9 months						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Dr. Anthony Riley				29c. License number D25205		29d. Date signed (Month, Day, Year) June 8, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley Game 6701 N. Charles St. Balto, Md 21208											
31. Date filed (Month, Day, Year) JUN 10 1999				32. Registrar's Signature Benjamin B. Sparks							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18545

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NORMAN FRANKLIN DRESSLER				2. Date of Death Month Day Year June 5 1999		3. Time of Death 5:10 AM		
	4a. Facility Name (If not institution, give street and number) ST. AGNES HEALTHCARE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 166-16-7651		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 76		8. Date of Birth (Month, Day, Year) DEC 21, 1922		
	9. Birthplace (State or Foreign Country) PENNSYLVANIA		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location ARBUTUS		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1200 JUNE ROAD		10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1-6-1940 to 10-2-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 5+) Collega (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PIPE FITTER		16b. Kind of Business/Industry LEVER BROS.					
17. Father's Name (First, Middle, Last) FELIX DRESSLER				18. Mother's Name (First, Middle, Maiden Summa) HELEN E. SMITH					
19a. Informant's Name/Relationship (Type, Print) MICKEY A. DRESSLER (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 238 WALGROVE ROAD - REISTERSTOWN, MARYLAND 21136					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK 6/7/99		20c. Location - City or Town, State ELKRIDGE, MARYLAND					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229					
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Renal cell cancer		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		23c. Approximate Interval Between Onset and Death 2 weeks					
23d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D46704		29d. Date signed (Month, Day, Year) June 5, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUTOMBO KANKONDE, ST AGNES HOSPITAL BLT MD				31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18547

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIE LOUISE FLAHERTY

2. Date of Death
Month Day Year

June 4 1999

3. Time of Death

6:39 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

5. Social Security Number

185-14-6225

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

JUNE 5, 1922

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2835 ROBERT AVE.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

DOMENICK MALA GESE

18. Mother's Name (First, Middle, Maiden Surname)

MAGDALENA ARCIDIANCO

19a. Informant's Name/Relationship (Type, Print)

MICHAEL FLAHERTY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3616 MELANIE RD., BALTIMORE, MD. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

JUNE 8

20c. Location - City or Town, State

PARKVILLE, MD.

21. Signature of Funeral Service Licensee

Heidi S. Wells

22. Name and Address of Facility

EVANS CHAPEL OF CHIMES

8800 HARFORD RD. PARKVILLE, MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

1 Hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Laurie Harris, MD

29c. License number

D 26116

29d. Date signed (Month, Day, Year)

June 4, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. LAURIE HARRIS 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21237

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

Laurie B. Sparks

State
Registrar

MARIE FLAHERTY 18

Baltimore, Maryland 21215-0020

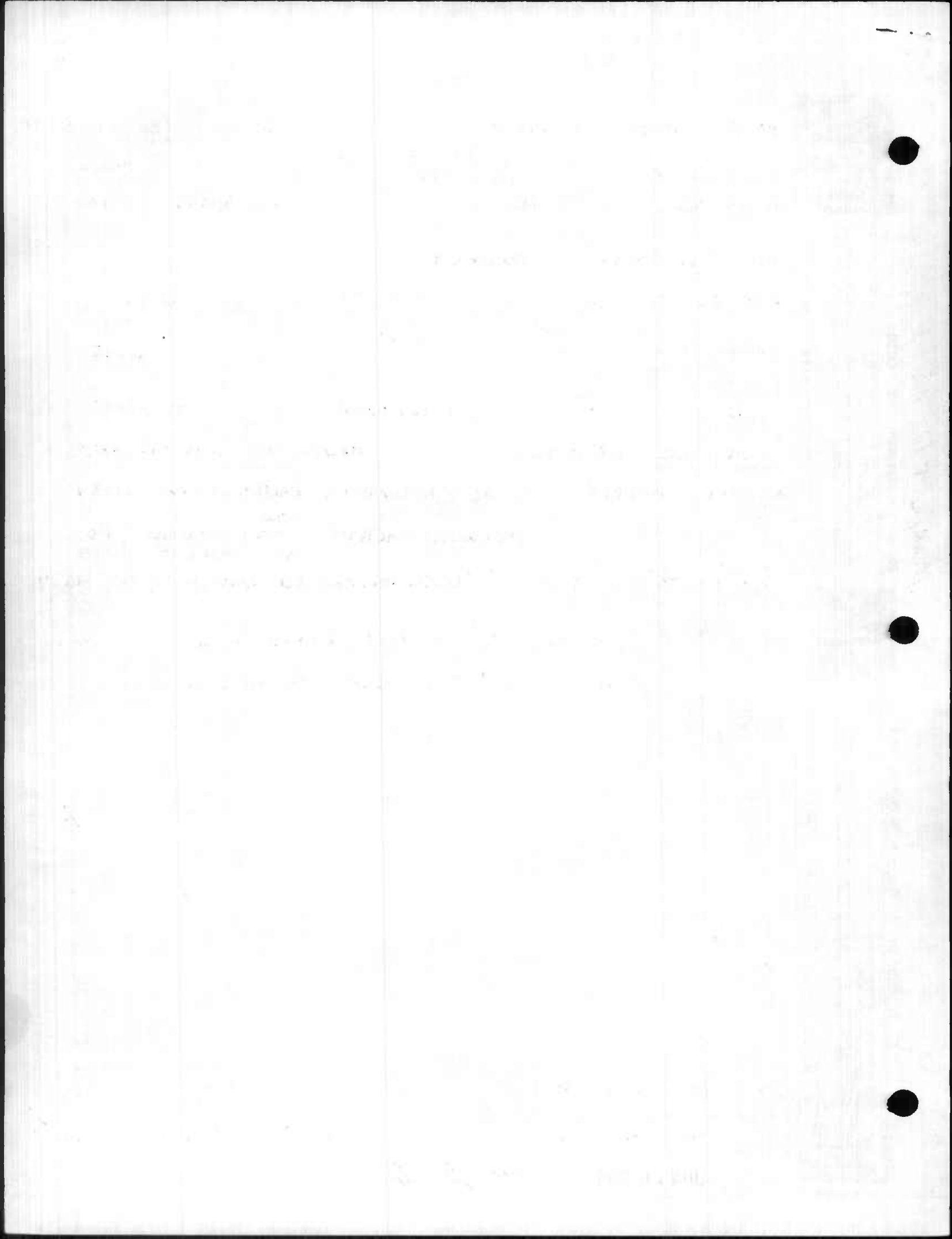
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18548

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANGELINA FLETCHER

2. Date of Death

JUNE 8 1999

3. Time of Death

1501 hrs

4a. Facility Name (If not institution, give street and number)

NORTH WEST HOSPITAL

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-12-9468

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/01/1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2803 Arlene Circle

10f. Zip Code

21207

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Assistant

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Ercole Corropoli

18. Mother's Name (First, Middle, Maiden Surname)

Elvira Corrinelli

19a. Informant's Name/Relationship (Type, Print)

Diana Douridas / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2803 Arlene Circle Baltimore MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore National

Date

6/11/99

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

Sean J. Imbriose

22. Name and Address of Facility

Ambrose Funeral Home of MD
Lansdowne 2719 Hammonds Ferry Rd Lansdowne 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Ravi Rao

29c. License number

D37333

29d. Date signed (Month, Day, Year)

JUNE 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. RAVI, MD, NHC, BALTO. MD 21133

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

1911-12

1. 1st of Jan. 1912. 1st of Feb. 1912. 1st of March 1912.

2. 1st of April 1912. 1st of May 1912. 1st of June 1912.

3. 1st of July 1912. 1st of Aug. 1912. 1st of Sept. 1912.

4. 1st of Oct. 1912. 1st of Nov. 1912. 1st of Dec. 1912.

ITEMS: #23 PART I, 27 PER MEO G772 6-30-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Starlett D. Frederick</u>				2. Date of Death Month Day Year <u>JUNE 2, 1999</u>		3. Time of Death <u>0416 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>FRANKLIN SQUARE HOSPITAL</u>				4b. City, Town, or Location of Death <u>ESSEX</u>		4c. County of Death <u>BALTIMORE</u>	
Funeral Director	5. Social Security Number <u>220-62-3612</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>46</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Aug 9 1952</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <u>Md</u>	10b. County <u>Baltimore</u>	10c. City, Town or Location <u>Parkville</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <u>3227 Putty Hill Ave.</u>			10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>USA</u>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>-</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Fraud prevention center</u>			16b. Kind of Business/Industry <u>Bell Atlantic</u>		
	17. Father's Name (First, Middle, Last) <u>Charles R. Von Nordeck</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Gloria Armstrong</u>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>John P. Frederick</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3227 Putty Hill Ave. Baltimore Md 21234</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Moreland Memorial Park</u>		20c. Location - City or Town, State <u>Parkville, Maryland</u>		20d. Date <u>June 7 1999</u>	
	21. Signature of Funeral Service Licensee <u>Krista S. Welles</u>				22. Name and Address of Facility <u>Evans Chapel of Memories</u> <u>8800 Harford Rd. Baltimore, Md 21234</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ACUTE ASTHMA</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <u>Theodore M. King</u>						
29c. License number <u>O.C.M.E.</u>		29d. Date signed (Month, Day, Year) <u>JUNE 3, 1999</u>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Theodore M. King</u> <u>111 Penn Street, Baltimore, Maryland 21201</u>								
State Registrar	31. Date filed (Month, Day, Year) <u>JUN 10 1999</u>		32. Registrar's Signature <u>Geneva B. Sparks</u>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VICTOR

FRENKIL

2. Date of Death
Month Day Year

June 3 1999

0030

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

213-18-2233

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

SEPT. 14, 1908

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3501 ST. PAUL ST. #1110

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

2 College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BUILDER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

ISAAC

FRENKIL

18. Mother's Name (First, Middle, Maiden Surname)

JENNIE

GOLDSCHIEDER

19a. Informant's Name/Relationship (Type, Print)

VICTOR FRENKIL, JR. / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1030 E. PATAPSCO AVE. - BALTIMORE, MD 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HAR SINAI CEMETERY

Date

6/6/99

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Disseminated Intravascular Coagulation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

> 2 wks

> 2 wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Renal Failure

Sacral Decubitus ulcer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

P12307

29d. Date signed (Month, Day, Year)

June 3, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LK Bonasera, MD

Sinai Hospital

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

[Signature]

State
Registrar

Victor Frenkil

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

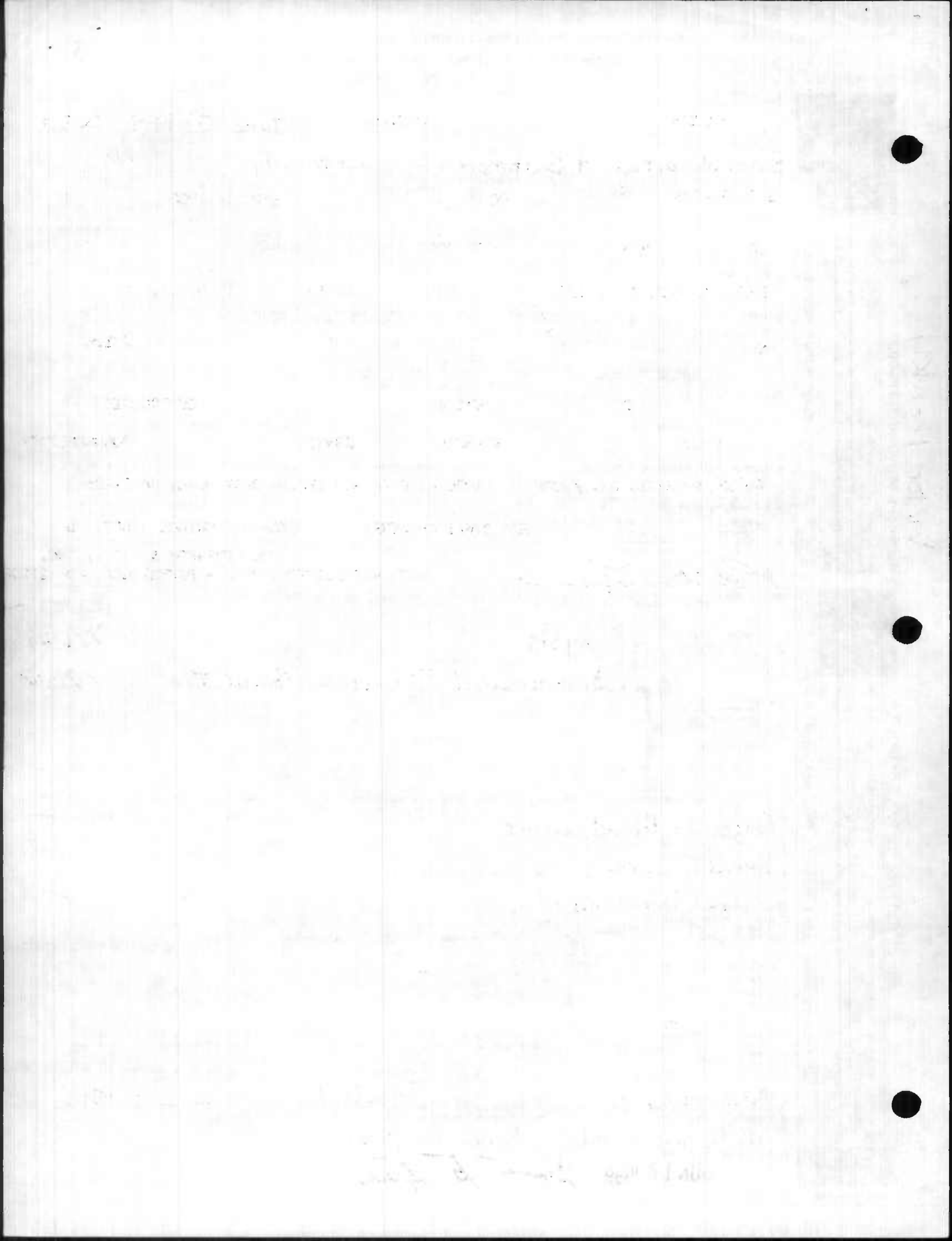
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

24



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18551

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Christopher Denhart Felder

2. Date of Death

June 5 1999

3. Time of Death

2:50 A.M.

4a. Facility Name (If not institution, give street and number)

Stella Maris Towson

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-74-4389

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

37

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
02 04 62

9. Birthplace (State or Foreign Country)

M.D.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6617 Marott Drive

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (14 or 5+)

na

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Meat Cutter

16b. Kind of Business/Industry

Farm Fresh

17. Father's Name (First, Middle, Last)

Thomas Felder

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Thomas

19a. Informant's Name/Relationship (Type, Print)

Charlotte Felder-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2621 Quantico Ave, Baltimore Md 21215

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc

Date

6/8/99

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

▶ Gladys Warner

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md

21215

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acquired Immune deficiency Syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part 1f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) Hospice

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ [Signature] MD

29c. License number

D43725

29d. Date signed (Month, Day, Year)

6/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHAMMOUD

821 N Eutan St. Unit 308 Baltimore MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

▶ [Signature]

Baltimore, Maryland 21215-0020

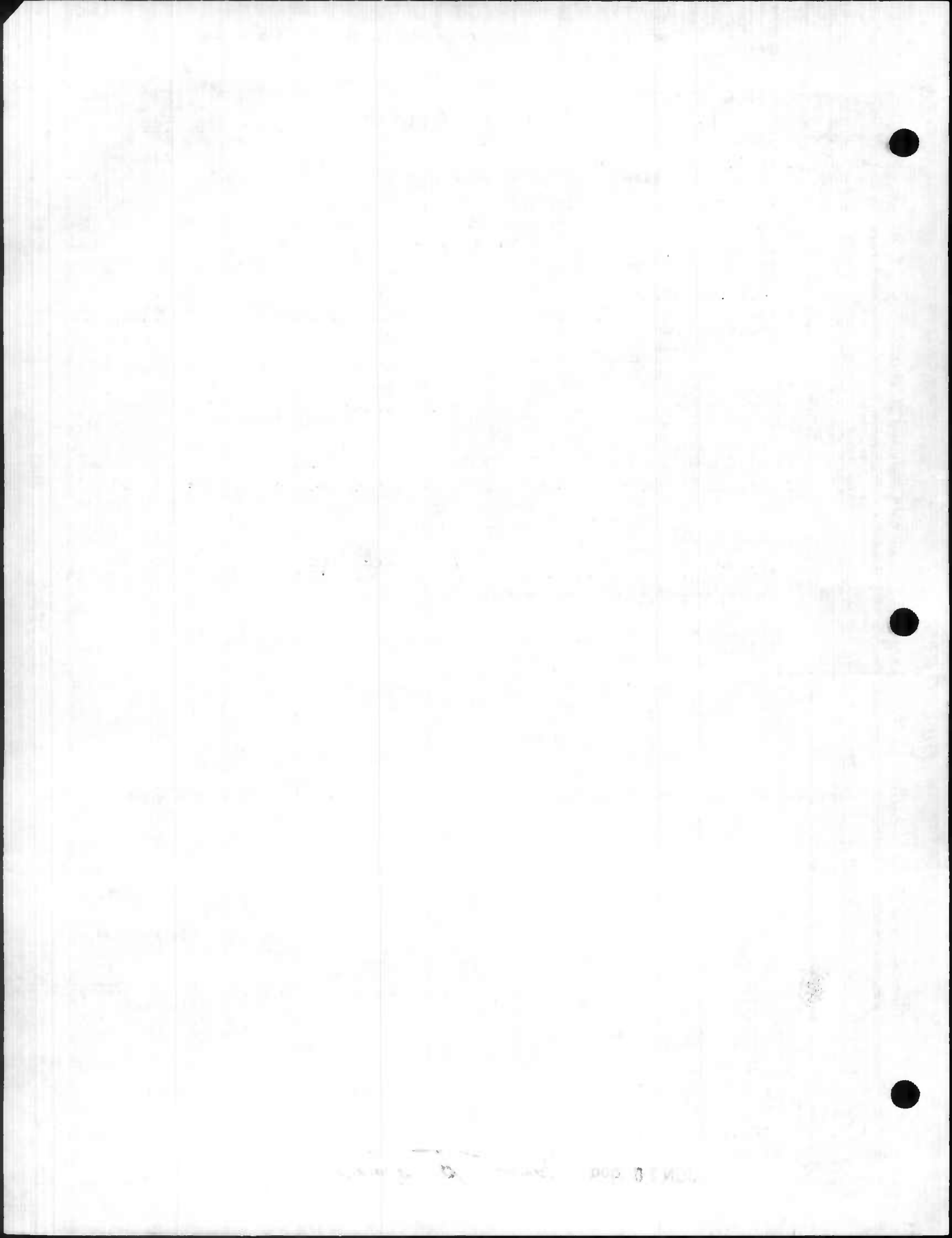
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18552

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ONEAL M. FOWLER				2. Date of Death Month Day Year JUNE 5 1999		3. Time of Death 15 03										
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A										
Funeral Director	5. Social Security Number 246-42-6419		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN 3, 1934	9. Birthplace (State or Foreign Country) COLUMBUS CO., NC									
	Usual Residence of Decedent																
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number 1604 CLARIDGE AVENUE				10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.											
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH GRADE College (1-4 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUSINESS AGENT		16b. Kind of Business/Industry MAKERS CARPENTER & CABINET											
17. Father's Name (First, Middle, Last) DOCTOR FOWLER					18. Mother's Name (First, Middle, Maiden Surname) VERNIE MERCER												
19a. Informant's Name/Relationship (Type, Print) GERALDINE M. FOWLER (WIFE)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 CLARIDGE AVENUE-BALTIMORE, MARYLAND 21227												
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Date 6/9/99		20c. Location - City or Town, State BALTIMORE										
21. Signature of Funeral Service Licensee <i>Quanta R. Thomas</i>					22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.																	
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. ADULT RESPIRATORY DISTRESS SYNDROME</td> <td rowspan="4">4 days</td> </tr> <tr> <td>b. DUE TO (or as a consequence of):</td> </tr> <tr> <td>c. STEROID DEPENDENT RADIATION PNEUMONITIS</td> </tr> <tr> <td>d. PNEUMONIA, ADENOCARCINOMA OF LUNG</td> </tr> <tr> <td></td> <td>d. PLEURAL EFFUSION</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ADULT RESPIRATORY DISTRESS SYNDROME	4 days	b. DUE TO (or as a consequence of):	c. STEROID DEPENDENT RADIATION PNEUMONITIS	d. PNEUMONIA, ADENOCARCINOMA OF LUNG		d. PLEURAL EFFUSION	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ADULT RESPIRATORY DISTRESS SYNDROME	4 days															
	b. DUE TO (or as a consequence of):																
	c. STEROID DEPENDENT RADIATION PNEUMONITIS																
	d. PNEUMONIA, ADENOCARCINOMA OF LUNG																
	d. PLEURAL EFFUSION																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MALIGNANT PERICARDITIS, DIABETES, slp PERICARDIAL STRIPPING, SEPSIS, CAD, PAROXYSMAL AFIB, CHF							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>A. Huffman</i>			29c. License number P12322		29d. Date signed (Month, Day, Year) JUNE 5, 1999									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANGELA HUFFMAN, MD SINAI HOSPITAL OF BALTIMORE																	
31. Date filed (Month, Day, Year) JUN 10 1999			32. Registrar's Signature <i>Anna B. Sparks</i>														

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

PATIENT KNOWN AS ONEAL FOWLER

AH12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18553

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CATHERINE FISCHER		2. Date of Death Month Day Year JUNE 7 1999		3. Time of Death 11:00 AM
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 212-05-1033	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 3/1/1908		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
10e. Street and Number 5810 Plumer Avenue		10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) II College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry C&P Telephone			
17. Father's Name (First, Middle, Last) Thomas Smith			18. Mother's Name (First, Middle, Maiden Surname) Catherine Gordan		
19a. Informant's Name/Relationship (Type, Print) Carol Wilson/Grand Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4510 Powell Avenue Baltimore, Maryland 21206		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State 6/11/99 Baltimore, Maryland	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206		
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a. MASSIVE UPPER GASTROINTESTINAL BLEEDING 7homs Due to (or as a consequence of): b. GASTRIC LYMPHOMA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 4 months					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.					
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Other: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier N. Dang M.D.		29c. License number P 11902	
29d. Data signed (Month, Day, Year) JUNE 7, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL 5601 LOCK RAVEN BLVD BALTIMORE MD 21239			
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18554

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IRVING BERNARD GLASSNER				2. Date of Death Month Day Year JUNE 3, 1999		3. Time of Death 5:40 PM		
	4a. Facility Name (If not institution, give street and number) 11 POMONA SOUTH #2				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 148-09-4959		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 9, 1917		
	9. Birthplace (State or Foreign Country) NJ		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 11 POMONA SOUTH #2		10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EXECUTIVE		16b. Kind of Business/Industry MANUFACTURING		17. Father's Name (First, Middle, Last) BENJAMIN GLASSNER		18. Mother's Name (First, Middle, Maiden Surname) LILLIAN TREMBOLIN	
19a. Informant's Name/Relationship (Type, Print) BENJAMIN GLASSNER / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 ROBIN DRIVE - HOCKESSIN, DE 19707		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH DAVID MEMORIAL PARK		20c. Location - City or Town, State 6/6/99 KENILWORTH, NJ	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarction Due to (or as a consequence of): b. systemic vasculitis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death Minutes			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hyperlipidemia atrial fibrillation myocardiopathy		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D07421		29d. Date signed (Month, Day, Year) 6/4/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Louis Miller MD 1838 Green Tree Rd #308 21208		31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18555

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VERA RUSHWORTH GARDNER				2. Date of Death Month Day Year MAY 29, 1999		3. Time of Death 9:00PM
	4a. Facility Name (If not institution, give street and number) ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 219-12-9064	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG 24, 1924	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location ANNAPOLIS			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 2108 BAY FRONT TERRACE			10f. Zip Code 21401		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COLUMNIST		16b. Kind of Business/Industry NEWS POST PAPER		
	17. Father's Name (First, Middle, Last) MAURICE RUSHWORTH				18. Mother's Name (First, Middle, Maiden Surname) FLORENCE ELIZABETH SHEETS		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) NANCY HAZARD GARDNER (DAUGHTER)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3413 LAKE MONTEBELLO DRIVE - BALTIMORE, MD 21218			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Date 6/4/99		20c. Location - City or Town, State BALTIMORE, MARYLAND
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229			
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>INTRACEREBRAL BLEED</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 20 YRS
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSION</u> <u>BREAST CANCER</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) N/A		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier  PHYSICIAN				29c. License number MD D39037		29d. Date signed (Month, Day, Year) 5-31-99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOUGLAS S MITCHELL, AMMC ANNAPOLIS MD 20214							
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18556

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Chester Paul Hickel				2. Date of Death Month Day Year JUNE 8, 1999		3. Time of Death 5:50 AM		
	4a. Facility Name (If not institution, give street and number) Stella Maris @ Mercy Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A		
Funeral Director	5. Social Security Number 728-10-5576		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 15, 1929		
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8193 Gum Tree Drive		10f. Zip Code 21222		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) G.E.D.		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Brakeman		16b. Kind of Business/Industry Patapsco B.R. Railroad					
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Eupha Gertrude Hickel					
19a. Informant's Name/Relationship (Type, Print) Mrs. Lawanda C. Hickel/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8193 Gum Tree Drive Dundalk, Maryland 21222					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 6/12/1999		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Prostate Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death unknown.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Stella Maris @ Mercy Hospice					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D40854		29d. Date signed (Month, Day, Year) JUNE 8, 1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID RISEBERG 301 St Paul Pl BALTIMORE MD 21202				31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18557

Patient known as: Anna Hedrick

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with this Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Elizabeth Hedrick				2. Date of Death Month Day Year June 6, 1999				3. Time of Death 1630		
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-26-7717		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) March 26, 1918		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1812 Marshall Road				10f. Zip Code 21222		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (1-4 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Casper Genco				18. Mother's Name (First, Middle, Maiden Surname) Maria Testudine							
19a. Informant's Name/Relationship (Type, Print) Mr. Edward S. Bouthner/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1812 Marshall Road Dundalk, Maryland 21222							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem.		20c. Date 6/11/99		20d. Location - City or Town, State Rossville, Maryland					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Multi Organ Failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number Res 000		29d. Date signed (Month, Day, Year) June 07 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nirit Weiss, MD 2401 W. Belvedere Ave Baltimore, MD 21215											
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 									

Art 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18558

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DONNELL HENRY

2. Date of Death

June 7th 1999

3. Time of Death

10:00 pm

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-68-2824

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

2-6-1957

9. Birthplace (State or Foreign Country)

BALTIMORE

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3701 MOHAWK AVE

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BETHLAHAM STEELE

16b. Kind of Business/Industry

WEIDER

17. Father's Name (First, Middle, Last)

JOHNNIE PERRY

18. Mother's Name (First, Middle, Maiden Surname)

CLARA PERRY

19a. Informant's Name/Relationship (Type, Print)

CLARA PERRY (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3015 BELMONT AVE, BALTO. MD 21216

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMETORY

Date

6-10-99 BALTO. MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HOWELL FUNERAL HOME

4600 LIBERTY HGHTS AVE, BALTO. MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal Failure

Due to (or as a consequence of):

b. END Stage AIDS

Due to (or as a consequence of):

c. PNEUMONIA

Due to (or as a consequence of):

d. Sepsis

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Therance L. Lamb MD

29c. License number

D37203

29d. Date signed (Month, Day, Year)

JUNE 7th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Therance L. Lamb MD Liberty Medical Center Baltimore, MD

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

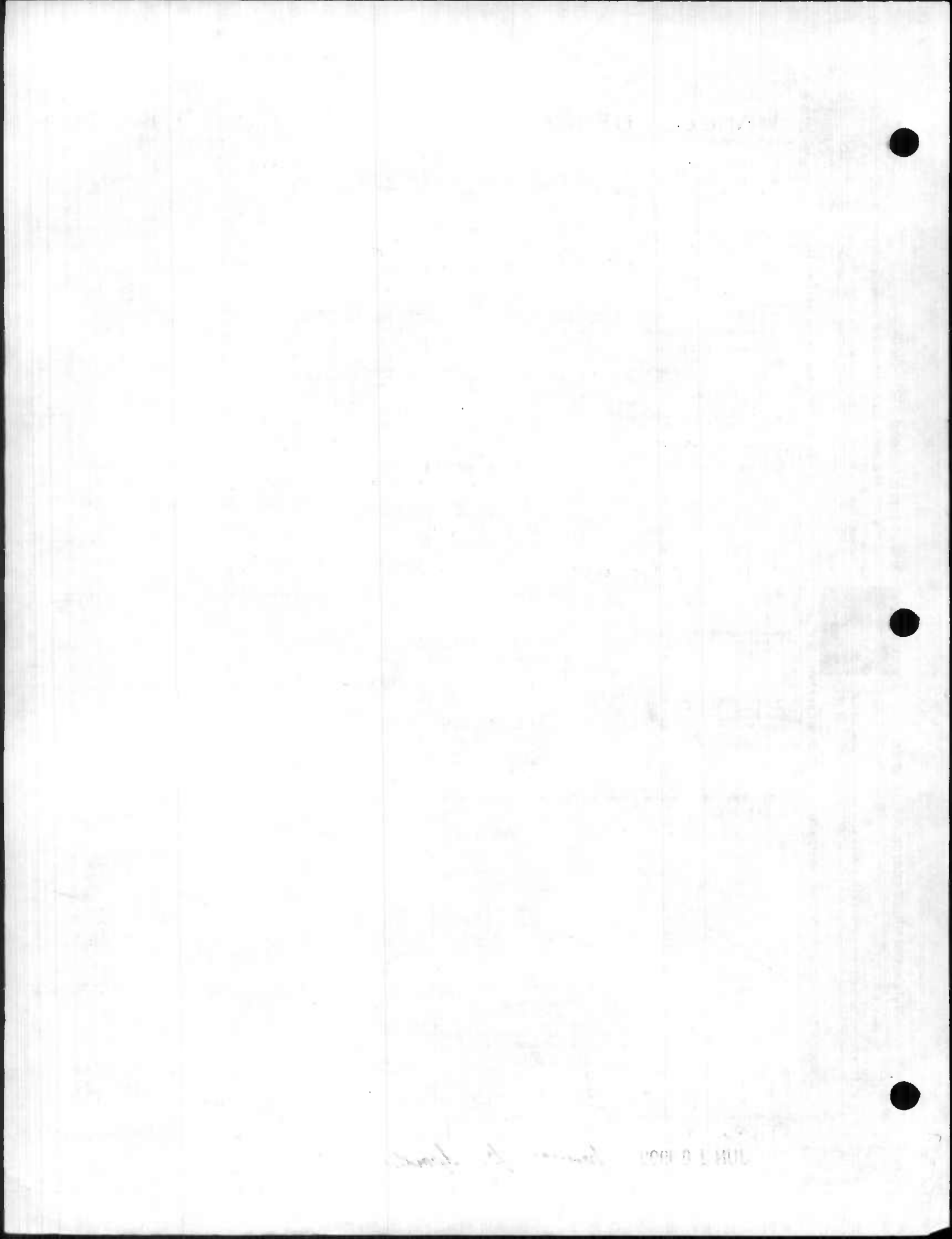
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



WRC
99-3215-510
NORE
HIGH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18559

ITEMS: #23 PART I, II, 27, 28A-F PER MEO G773

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

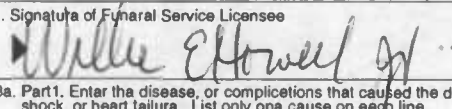
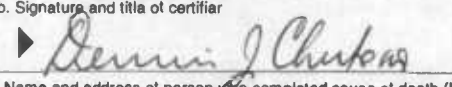
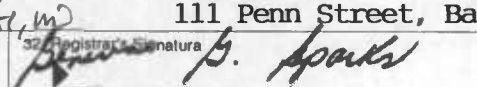
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) NORA HIGH		2. Date of Death Month Day Year JUNE 06, 1999		3. Time of Death 5:12 PM.	
4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number UNKNOWN		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.	
8. Date of Birth (Month, Day, Year) 11-2-46		9. Birthplace (State or Foreign Country) KINSTON, NC			
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6202 ELLIOTT STREET		10f. Zip Code 21226	
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED		16b. Kind of Business/Industry HOUSEWIFE	
17. Father's Name (First, Middle, Last) URIE ANDERSON		18. Mother's Name (First, Middle, Maiden Surname) KATHLEEN VAUSE			
19a. Informant's Name/Relationship (Type, Print) GLADYS ANDERSON (SISTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 452 KING RD, GREEN, NEW YORK 13778			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) metro crematory		20c. Location - City or Town, State 6-10-99 BALTO.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HIGHTS AVE, BALTO, MD 21207			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MIXED DRUG INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6-6-99		28b. Time of Injury (Hour, Minute) 4:00	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found At House	
28f. Location (Street and Number or Rural Route Number, City or Town, State) BALTIMORE, MARYLAND		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 07, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, 111 Penn Street, Baltimore, Maryland 21201	
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 			

SPYING THE

copy to me
PAGE 01000

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#17,19a perFH G772 6/10/99 EW

Certificate of Death

Reg. No.

99 18560

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) James J Hajek				2. Date of Death Month 6 Day 9 Year 99		3. Time of Death 05:02	
4a. Facility Name (If not institution, give street and number) University of Maryland hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
5. Social Security Number 216-52-1791		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 20, 1948	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 117 Elinor Avenue				10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Vietnam Era		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Analyst		16b. Kind of Business/Industry U.S. Government	
17. Father's Name (First, Middle, Last) James J. Hajek Hajek				18. Mother's Name (First, Middle, Maiden Surname) Ramona Serio			
19a. Informant's Name/Relationship (Type, Print) Christine Hajek (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29447 Petunia Drive, Easton, MD 21601			
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial Gard.		Date 6/12/99		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sepsis Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Multiple Myeloma Due to (or as a consequence of):						Approximate Interval Between Onset and Death 1 week	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Renal Failure						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
24a. Was an autopsy performed? 1 Yes 2 No						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier MD				29c. License number UP [P]12439		29d. Date signed (Month, Day, Year) 6/9/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sahas Madhiraju University of Maryland hospital							
31. Date filed (Month, Day, Year) JUN 10 1999				32. Registrar's Signature 			

State
Registrar

99 18561

DMMH 16 Rev 6/95

448 14001 6/4/99

Baltimore, Maryland 21215-0020

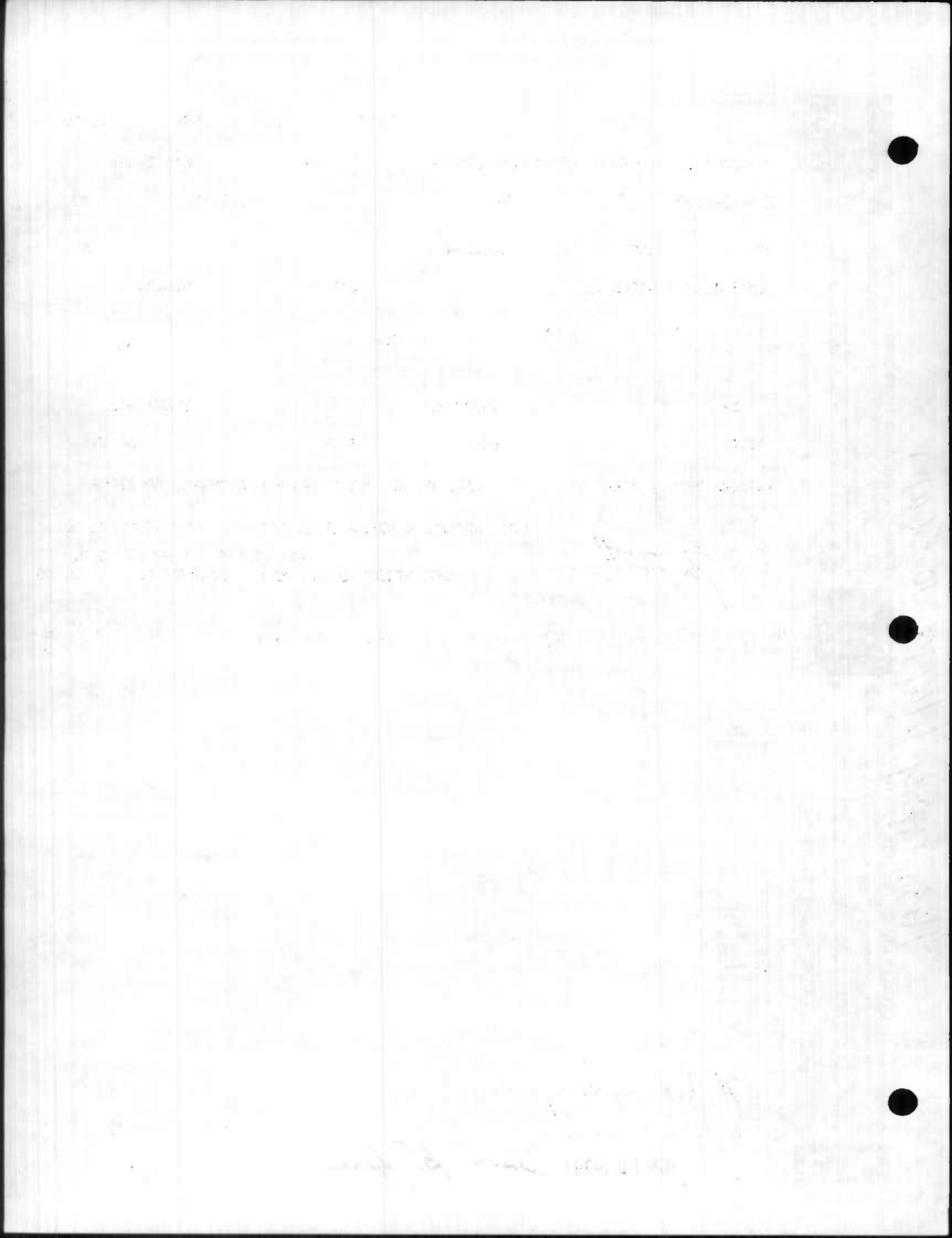
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18562

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN I. HARDY				2. Date of Death Month Day Year MAY 29, 1999				3. Time of Death 9:30 AM	
	4a. Facility Name (If not institution, give street and number) 5444 DOGWOOD ROAD				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-14-1153		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 73		8. Date of Birth (Month, Day, Year) APRIL 4, 1925		9. Birthplace (State or Foreign Country) BALTIMORE	
	Usual Residence of Decedent				10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3642 GREENVALE ROAD		10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 11-20-42 to 4-12-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH GRADE College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry FREIGHT					
	17. Father's Name (First, Middle, Last) JOHN H. HARDY				18. Mother's Name (First, Middle, Maiden Surname) Unknown EISENBAUGH					
	19a. Informant's Name/Relationship (Type, Print) RAMONA S. HARDY (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3642 GREENVALE ROAD - BALTIMORE, MARYLAND 21229					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) MAUSOLEUM		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		20c. Location - City or Town, State BROOKLYN PARK, MD					
	21. Signature of Funeral Service Licensee Jackie D. Shannon				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229					
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 5 min									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) GROUP HOME					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier JW Cook IV MD		29c. License number 044243		29d. Date signed (Month, Day, Year) June 3, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW Cook IV MD				1120 N. ROLLING ROAD - BALTIMORE, MARYLAND 21228						
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature James B. Sparks								

Deborah L. Hall
 ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-24-99 WR.
 AMENDED ITEM #18 PER FH G772 6/10/99AAH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18563

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Deborah L. Hall				2. Date of Death Month Day Year June 03, 1999		3. Time of Death 11:56 A.M.	
	4e. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 262-08-2573		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) August 16, 1953	
	9. Birthplace (State or Foreign Country) Florida		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8 Clinton Hill Court		10f. Zip Code 21228		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry College				
17. Father's Name (First, Middle, Last) Laurence E. Milligan				18. Mother's Name (First, Middle, Maiden Surname) Mary MARIA Pagan				
19a. Informant's Name/Relationship (Type, Print) James Lee Hall/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Clinton Hill Court Catonsville, Maryland 21228				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 6/5/99		
21. Signature of Funeral Service Licensee Quanta R. Thomas				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. DILTIAZEM INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found: 6-2-99		28b. Time of Injury Found: M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred UNKNOWN		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: RESIDENCE		28f. Location (Street and Number or Rural Route Number, City or Town, State) 8 CLINTON HILL COURT, CATONSVILLE, MARYLAND				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Wayne Melville				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 04, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. S. P. Kossu 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10-10-67

10-10-67

10-10-67

10-10-67

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18564

JOHNSON, FRANCES

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Eileen Johnson						2. Date of Death Month JUNE Day 6 Year 1999		3. Time of Death 9:45PM		
	4a. Facility Name (If not institution, give street and number) Mercy Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death -----		
Funeral Director	5. Social Security Number 220-26-8275		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 7, 1930		9. Birthplace (State or Foreign Country) MD		
	10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 3211 Mayfair Road		10f. Zip Code 21207		10g. Citizen of What Country? USA							
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) computer programmer		16b. Kind of Business/Industry Banking							
17. Father's Name (First, Middle, Last) Vesper Lovell Morris						18. Mother's Name (First, Middle, Maiden Summa) Emily Frances Lomax					
19a. Informant's Name/Relationship (Type, Print) Lloyd J. Johnson-Husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3211 Mayfair Road, Baltimore, MD 21207					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park		20c. Location - City or Town, State 6/9/99 Glen Burnie, MD							
21. Signature of Funeral Service Licensee John O. Mitchell IV						22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, MD 21212					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Breast Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) STELLA MARIS AT MERCY HOSPICE											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier Del Amy M						29c. License number D40854		29d. Date signed (Month, Day, Year) JUNE 6, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID RISEBERG, 301 ST PAUL PI, BALTIMORE, MD 21202											
31. Date filed (Month, Day, Year) JUN 10 1999						32. Registrar's Signature B. Sparks					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEONARD M. KUTRIK

2. Date of Death

Month Day Year
JUNE 2 1999

3. Time of Death

2:45 PM

4a. Facility Name (If not institution, give street and number)

HCR MANOR CARE TOWSON

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

220-12-5182

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

DEC. 21, 1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKTON

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

20016 YORK ROAD

10f. Zip Code

21120

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

MILLWRIGHT OPERATOR

16b. Kind of Business/Industry

PIPELINE

17. Father's Name (First, Middle, Last)

MICHAEL KUTRIK

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA POSLUSZNY

19a. Informant's Name/Relationship (Type, Print)

AUGUSTA L. KUTRIK, SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20016 YORK RD. PARKTON MD. 21120

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HOLY CROSS P.N.C. CEMETERY

Date

JUNE 7

20c. Location - City or Town, State

DUNDALK, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS CHAPEL OF CHIMES

2325 YORK RD. TIMONUM, MD. 21093

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

C.O.R.D.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. pneumonia Due to (or as a consequence of):

b. Dehydration Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

7 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Pending investigation

☐ Accident

☐ Suicide

☐ Homicide

☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner:

On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

042736

29d. Date signed (Month, Day, Year)

6-3-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AYMAN F. ALKAD, MD 7600 OSLER DR. STE 203 TOWSON, MD 21204

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

GEORGE

KAHLER JR. ITEMS: #23 PART I, 27, 28C PER MEO G773 7-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

Certificate of Death

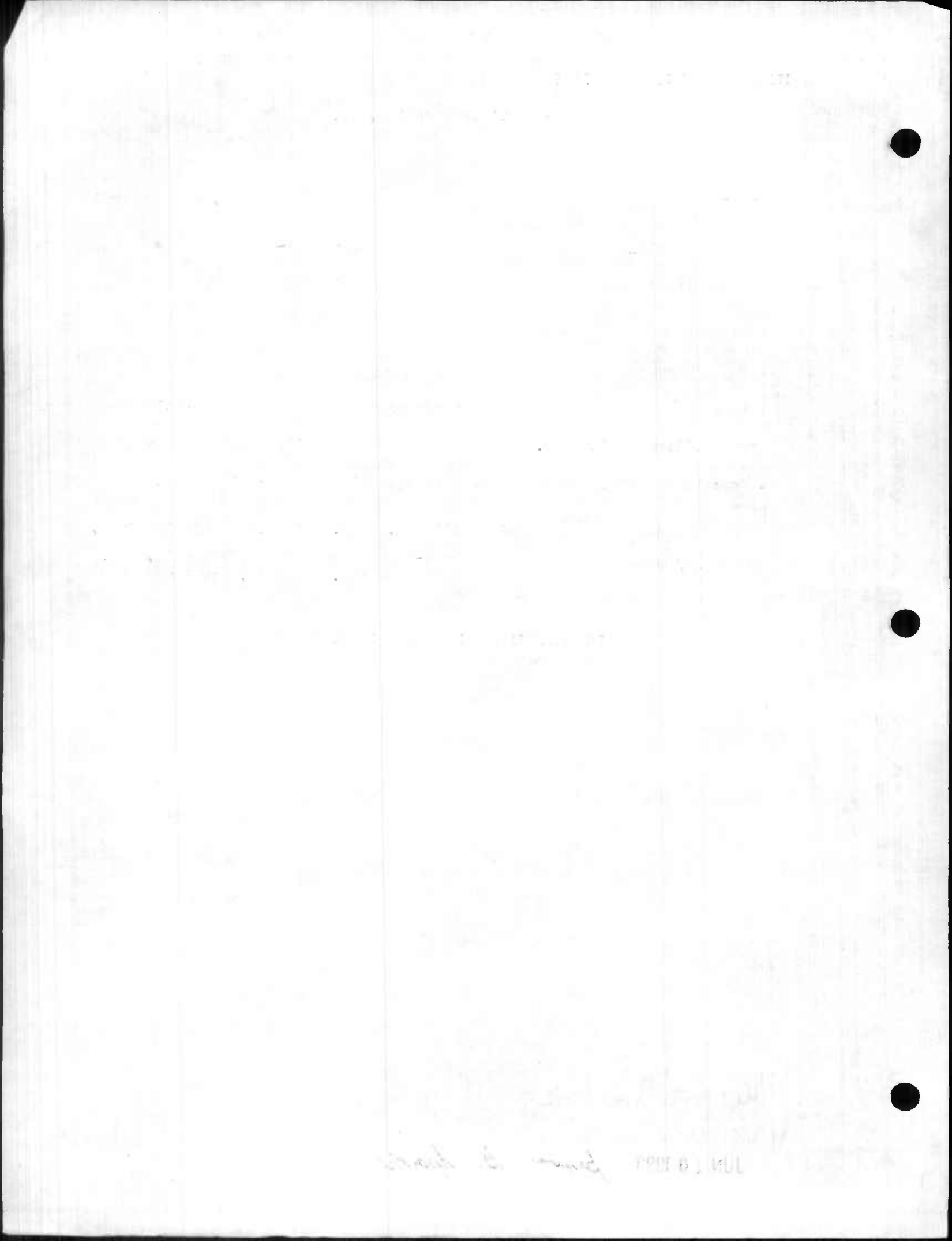
Reg. No.

89 18566

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George William Kahler, Jr.		2. Date of Death Month: JUNE Day: 8 Year: 1999		3. Time of Death 3:50P.M.
	4a. Facility Name (If not Institution, give street and number) ST. AGNES HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 213-68-4049	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	8. Date of Birth (Month, Day, Year) June 29, 1955	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Middle River		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 3502 Honeysuckle Lane		10f. Zip Code 21220		10g. Citizen of What Country? United States
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 9 Years College (1-4 or 5+):		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction		16b. Kind of Business/Industry Asphalt Contractors		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) George William Kahler, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Lillie Josephine Farish		
	19e. Informant's Name/Relationship (Type, Print) Mrs. Josephine Kahler/Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3502 Honeysuckle Lane Middle River, MD 21220		
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gdns. 6/12/1999		20c. Location - City or Town, State Middle River, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) JUNE 9, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRISON KAHLE JR 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUN 10 1999 32. Registrar's Signature					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18567

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Kalendek				2. Date of Death Month June Day 7 Year 1999				3. Time of Death 11:30 AM	
	4a. Facility Name (If not institution, give street and number) Franklin Woods-Genesis Elder Care				4b. City, Town, or Location of Death Baltimore				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-46-3676		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 17, 1912		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 6930 Eastbrook Avenue				10f. Zip Code 21224		10g. Citizen of What Country? 21224			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		College (14 or 5+) College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Joseph Cieslak				18. Mother's Name (First, Middle, Maiden Surname) Julia Radomska					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Alvin J. Kalendek Jr. (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2419 Hanson Road, Edgewood, Maryland 21040					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Mary		Date 6/11/99		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee Bruce A. Wellen				22. Name and Address of Facility Schimunek Funeral Home, Inc. 3331 Brehms Lane, Baltimore, MD 21213					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASCVD Due to (or as a consequence of): a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 months									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
State Registrar	29b. Signature and title of certifier S. Raguey				29c. License number D0053720				29d. Date signed (Month, Day, Year) 06/09/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2112, Belair Rd, Suite #9, Fallston, MD 21047									
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18568

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARLENE

2. Date of Death

Month

Day

Year

LANDIS

JUNE

09

1999

3. Time of Death

11:35

Funeral
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

—

5. Social Security Number

216-28-4422

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

DEC 5, 1932

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3218 ACTON RD.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FOREIGN SERVICE SECRETARY

16b. Kind of Business/Industry

U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

DOYLE W. LANDIS

18. Mother's Name (First, Middle, Maiden Surname)

MARIE A. BOSSON

19a. Informant's Name/Relationship (Type, Print)

CAROL OHRENBERGER / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

95 ST. IVES C.C. DRIVE DULUTH, GA. 30093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GARDENS OF FAITH

Date

JUNE 12,
1999

20c. Location - City or Town, State

ROSEDALE MD.

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES

8800 HARFORD RD. PARKVILLE, MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CHRONIC LYMPHOCYTIC LEUKEMIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

11 YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

David Zaas MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JUNE 09, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID ZAAS, MD, TOWER 110, 600 NORTH WOLFFE, BALTIMORE, MARYLAND 21287

State
Registrar

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

James B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

18569

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE MAYNARD LEPSON				2. Date of Death Month Day Year June 5 1999		3. Time of Death 7:00 AM	
	4a. Facility Name (If not institution, give street and number) 88 W. Kingston Park Lane				4b. City, Town, or Location of Death Middleriver		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-01-5405		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 102 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 20, 1897	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location MIDDLERIVER	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 88 W. KINGSTON PARK LANE		10f. Zip Code 21220		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANIC		16b. Kind of Business/Industry AUTO			
	17. Father's Name (First, Middle, Last) GEORGE LEPSON				18. Mother's Name (First, Middle, Maiden Surname) ELLA HARTMAN			
	19a. Informant's Name/Relationship (Type, Print) NAOMI LEPSON/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 88 W. KINGSTON PARK LANE, BALTIMORE, MD. 21220			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY		20c. Date 6/8/99		20d. Location - City or Town, State BALTIMORE, MD.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD. 21224			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. congestive heart failure Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D 20673		29d. Date signed (Month, Day, Year) 6-7-99	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Lowe 7672 Belgin Rd Ma, Kinore, MD 21236							
	31. Date filed (Month, Day, Year) JUN 10 1999				32. Registrar's Signature 			

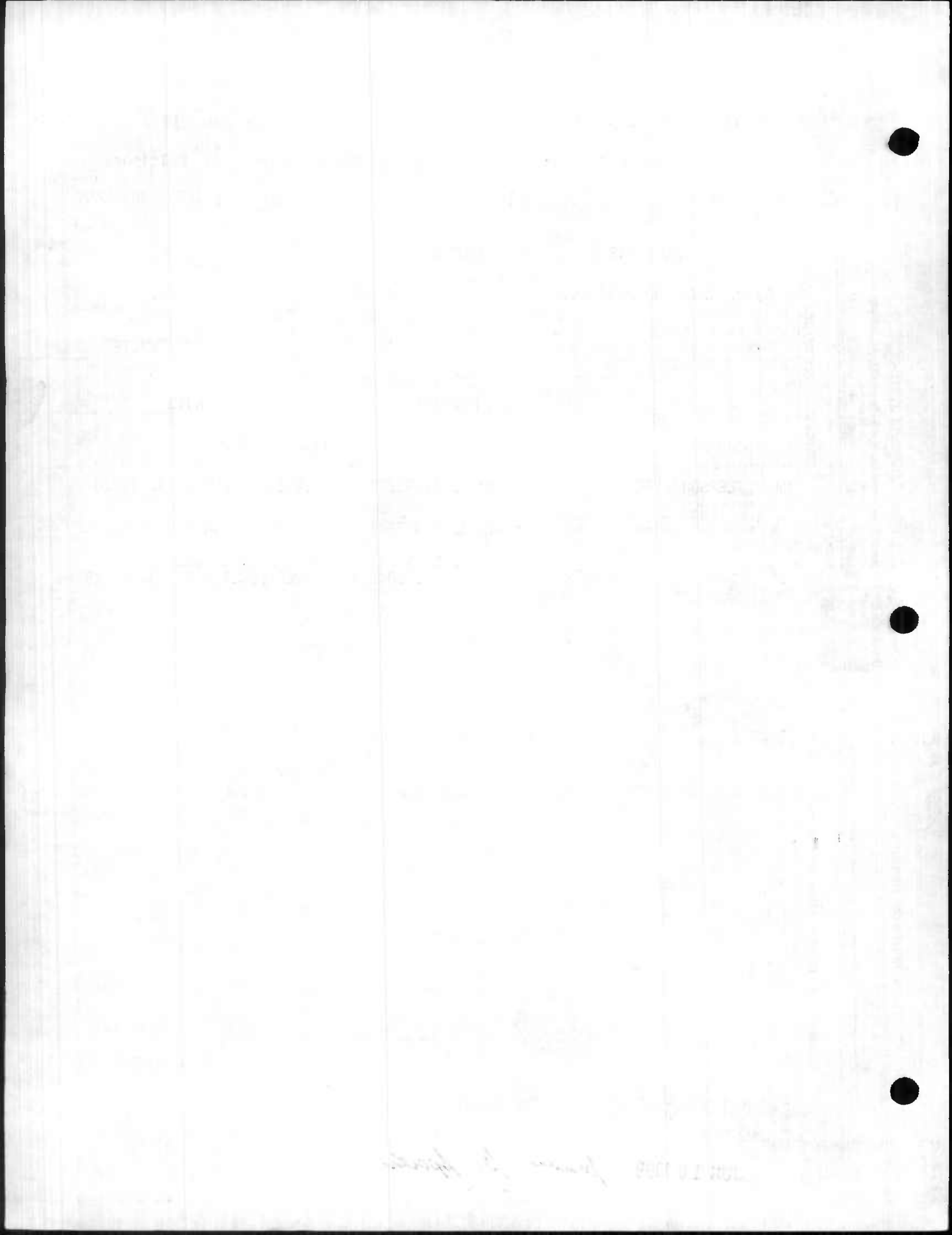
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18570

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theodore D. Marsh, Sr.						2. Date of Death Month June Day 10 Year 1999		3. Time of Death 8:00 AM		
	4a. Facility Name (If not institution, give street and number) 2915 Virginia Ave.						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 216-24-9925		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) 08/14/1929		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore Highlands				10d. Inside City Limits 1 Yes 2 No			
10e. Street and Number 2915 Virginia Ave.				10f. Zip Code 21227		10g. Citizen of What Country? United States					
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 8/21/46 If Yes, Give Year or Dates: 2/9/48		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal Worker			16b. Kind of Business/Industry Sheet Metal				
17. Father's Name (First, Middle, Last) Filbert Marsh						18. Mother's Name (First, Middle, Maiden Surname) Bessie Leister					
19a. Informant's Name/Relationship (Type, Print) Helen M. Marsh / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2915 Virginia Ave Baltimore MD 21227							
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial		20c. Date 6/12/99		20d. Location - City or Town, State Dorsey, MD					
21. Signature of Funeral Service Licensee Dean P. Imbease				22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd Lansdowne MD 21227							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Emphysema Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
								24a. Was an autopsy performed? 1 Yes 2 No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)									
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Stuart Jacobs MD		29c. License number 022483		29d. Date signed (Month, Day, Year) June 10, 1999							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STUART JACOBS MD 200 Hospital Dr. Glen Burnie, MD 21061											
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature Stuart Jacobs									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

June 12, 1909

Dear Mr. [illegible]

I have just received your letter of the 10th inst.

and am glad to hear that you are interested in the [illegible]

of the [illegible] and the [illegible]

of the [illegible] and the [illegible]

of the [illegible] and the [illegible]

of the [illegible] and the [illegible]

of the [illegible] and the [illegible]

of the [illegible] and the [illegible]

of the [illegible] and the [illegible]

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of the [illegible] and the [illegible]

of the [illegible] and the [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18571

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Ruth Mitchell				2. Date of Death Month 5 Day 14 Year 99		3. Time of Death 7:11 am	
4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Chesley		4c. County of Death Prince Georges	
5. Social Security Number 093-24-5093		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 24, 1931	
9. Birthplace (State or Foreign Country) ALABAMA				10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. State NY		10b. County Monroe		10c. City, Town or Location Rochester		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 63 Reynolds Avenue				10f. Zip Code 14609-1150		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife		16b. Kind of Business/Industry private	
17. Father's Name (First, Middle, Last) Eddy B. Harris				18. Mother's Name (First, Middle, Maiden Surname) Lillian Mae Kirk			
19a. Informant's Name/Relationship (Type, Print) Randolph Mitchell/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 Doral Dr. Mitchellsville, MD 20721			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oatka Cemetery		Date 5-20-99		20c. Location - City or Town, State Scottsville, NY	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave., NW Wash., DC 20011			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. Cardiovascular arrest Due to (or as a consequence of):</p> <p>b. Congestive heart failure Due to (or as a consequence of):</p> <p>c. Upper GI bleeding Due to (or as a consequence of):</p> <p>d. Pre-renal azotemia</p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Esophageal carcinoma Calcemia						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dr. [Signature] Medical Resident		29c. License number D0053218		29d. Date signed (Month, Day, Year) 5/14/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMIA A. SORIAL Prince Georges Hospital							
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature [Signature]					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEM: 5 PER F.H. G772 6-15-99 WR.

99 18572

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSIE MILES				2. Date of Death Month Day Year June 5, 1999				3. Time of Death 6:50 pm	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-32-4691		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) 12-26-30		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1333 N. Elwood Avenue				10f. Zip Code 21213		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service			16b. Kind of Business/Industry Sparrow Point		
	17. Father's Name (First, Middle, Last) Henry Jeramon				18. Mother's Name (First, Middle, Maiden Surname) Josephine White					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Melvin Miles				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 1333 North Ellwood Avenue Baltimore, MD					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem. 06-11-99 Owings Mills,		20c. Location - City or Town, State MD			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intracerebral Hemorrhage Due to (or as a consequence of): b. Herniation Due to (or as a consequence of): c. Brain Tumor Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 days 3 hours 7 days									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>[Signature]</i> Neuroscience Attending				29c. License number D36133		29d. Date signed (Month, Day, Year) June 5, 1999			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John Ulatowski 600 N. Wolfe Street Baltimore, Maryland 21287									
	31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature <i>[Signature]</i>							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18573

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>JOHN MORTON</u>				2. Date of Death Month <u>JUNE</u> Day <u>07</u> Year <u>1999</u>				3. Time of Death <u>0530</u>		
	4a. Facility Name (If not institution, give street and number) <u>JOHNS HOPKINS Bayview Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>NA</u>		
Funeral Director	5. Social Security Number <u>210-44-5626</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>51</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>5-26-48</u>		9. Birthplace (State or Foreign Country)		
	10a. State <u>MD</u>				10b. County <u>NA</u>		10c. City, Town or Location <u>Baltimore</u>				
10d. inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <u>1851 North Collington Avenue</u>				10f. Zip Code <u>21213</u>		10g. Citizen of What Country? <u>USA</u>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th grade</u> College (1-4or 5+) <u>NA</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Sanitation</u>				16b. Kind of Business/Industry <u>City of Baltimore</u>			
17. Father's Name (First, Middle, Last) <u>EliJah Morton, Sr.</u>						18. Mother's Name (First, Middle, Maiden Sumama) <u>Althea Patterson</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Margaret Kane</u>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1851 N. Collington Street Baltimore, MD 21213</u>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Voshell Mem. Gardens</u>				20c. Location - City or Town, State <u>06-10-99 Dundalk, MD</u>			
21. Signature of Funeral Service Licensee <u>[Signature]</u>						22. Name and Address of Facility <u>Baltimore, Maryland 21202</u> <u>WM.C.March FH 1101 E. North Avenue</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) a. <u>Progressive Multifocal Leukoencephalopathy</u> 1 month Due to (or as a consequence of): b. <u>Advanced Acquired Immunodeficiency Syndrome</u> 5 years Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cytomegalovirus infection</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day Year)		28b. Time of injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <u>P. Barditch MD</u>				29c. License number <u>D35701</u>		29d. Date signed (Month, Day, Year) <u>6/7/99</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>P. Barditch MD</u> <u>4950 Eastern Avenue Baltimore, MD 21224</u>											
31. Date filed (Month, Day, Year) <u>JUN 10 1999</u>				32. Registrar's Signature <u>[Signature]</u>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18574

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theodore Moore				2. Date of Death Month Day Year June 05, 99		3. Time of Death 17:09pm	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 238-56-5462		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) 02-28-29	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) NC		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits	
	10e. Street and Number 1330 N. Luzerne Avenue		10f. Zip Code 21213		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer		16b. Kind of Business/Industry MD. Cup Company			
	17. Father's Name (First, Middle, Last) Sam Moore		18. Mother's Name (First, Middle, Maiden Surname) Maggie Lee		19a. Informant's Name/Relationship (Type, Print) Werenith Moore		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 1330 N. Luzerne Avenue Baltimore, Maryland	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery		20c. Location - City or Town, State 06-11-99 Baltimore, MD			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Baltimore, Maryland 21202 WM. C. March FH 1101 E. North Avenue		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Coronary artery disease Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Sleep Apnoea.		23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier. Shalini Kamal MD		29c. License number 00039788		29d. Date signed (Month, Day, Year) 6/7/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shalini Kamal. 9512 N. Hanford Rd. Balt. MD 21234		31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature <i>[Signature]</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18575

Alexander Murchison

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Alexander Murchison, Sr.		2. Date of Death Month <u>June</u> Day <u>8</u> Year <u>1999</u>		3. Time of Death <u>1050 pm</u>	
4a. Facility Name (If not institution, give street and number) <u>Maryland General Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>n/a</u>	
5. Social Security Number <u>215 30 9165</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>65</u> Yrs.	
8. Date of Birth (Month, Day, Year) <u>March 27, 1934</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>			
10a. State <u>Maryland</u>		10b. County <u>n/a</u>		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>717 Druid Park Dr., Apt. 512</u>		10f. Zip Code <u>21217</u>	
10g. Citizen of What Country? <u>United States</u>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>1952-56</u>	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Housekeeping Technician</u>		16b. Kind of Business/Industry <u>Hospital</u>	
17. Father's Name (First, Middle, Last) <u>John Murchison</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Mattie Mc Neil</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Barbara Murchison / Wife</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1607 N. Caroline St., Baltimore, MD 21213</u>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Green Mount Crematory</u>		20c. Location - City or Town, State <u>Baltimore, MD</u>	
21. Signature of Funeral Service Licensee <u>Stephen D. Lohrmann</u>		22. Name and Address of Facility <u>CAFA Stephen D. Lohrmann P.A.</u> <u>8717 Green Pastures Dr., Baltimore, MD 21286</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Massive Gastrointestinal Bleeding</u> Due to (or as a consequence of): <u>Gram Negative Sepsis</u> Due to (or as a consequence of): <u>Gastric Lymphoma</u> Due to (or as a consequence of): <u></u>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death	
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u></u>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u></u>		28b. Time of Injury <u>M</u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <u></u>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u></u>	
28f. Location (Street and Number or Rural Route Number, City or Town, State) <u></u>		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>James Tansinda MD</u>	
29c. License number <u>P12678</u>		29d. Date signed (Month, Day, Year) <u>6/8/99</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>James Tansinda, M.D. C/O Maryland General Hospital</u>		31. Date filed (Month, Day, Year) <u>JUN 10 1999</u>		32. Registrar's Signature <u>Bernard B. Sparks</u>	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18576

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rosa Ilardo Muransky

2. Date of Death

Month Day Year
June 10, 1999

3. Time of Death

1:30 AM

4a. Facility Name (If not institution, give street and number)

1302 Scottsdale Drive, Apt. G

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

213-32-4912

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 20, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1302 Scottsdale Drive, Apt. G

10f. Zip Code

21015

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

Salvatore Ilardo

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Tamburo

19a. Informant's Name/Relationship (Type, Print)

Meghan M. DiCocco (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

411 Winslow Drive, Bel Air, MD 21015

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

6/11/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schmunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Rd., Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

D45390

29d. Date signed (Month, Day, Year)

6/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6830 HOSPITAL DR #200, BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18577

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Christine Stefanie Moldrzyk

2. Date of Death

Month
June

Day

9,

Year

1999

3. Time of Death

12:45 A.M.

4a. Facility Name (If not institution, give street and number)

5313 Wright Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-92-4199

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

20

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
June 27, 1978

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5313 Wright Avenue

10f. Zip Code

21205

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10th Grade

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dependent

16b. Kind of Business/Industry

Never Worked

17. Father's Name (First, Middle, Last)

Eugeniusz S. Moldrzyk

18. Mother's Name (First, Middle, Maiden Summa)

Susan Dickinson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Susan E. Moldrzyk (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5313 Wright Avenue, Baltimore, Maryland 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gardens Of Faith

Date

6/11/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

▶ Robert J. Rodal

22. Name and Address of Facility

Schimunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 2121323a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Glioblastoma Multiforme

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

15 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Robert J. Rodal

29c. License number

D0052777

29d. Date signed (Month, Day, Year)

6/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Loeb 600 N Wolfe St CMSC800 Baltimore MD 21287

State
Registrar

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

▶ Geneva B. Sparks

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-d show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18578

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Francisco J. Mendes
2. Date of Death Month Day Year JUNE 9 1999
3. Time of Death 2:50 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number) Doctors' Community Hospital
4b. City, Town, or Location of Death Lanham
4c. County of Death Prince George's

5. Social Security Number 153 52 6128
6. Sex ☒ M ☐ F
7. Age (In yrs. last birthday) 44 Yrs.
8. Date of Birth (Month, Day, Year) May 19 1955
9. Birthplace (State or Foreign Country) Portugal

Usual Residence of Decedent
10a. State Maryland
10b. County Prince George's
10c. City, Town or Location Bowie
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 3833 Eaves Lane
10f. Zip Code 20716
10g. Citizen of What Country? Portugal

11. Marital Status
1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales
16b. Kind of Business/Industry Retail

17. Father's Name (First, Middle, Last) Artur Mendes
18. Mother's Name (First, Middle, Maiden Surname) Maria da Conccicao

19a. Informant's Name/Relationship (Type, Print) Maria Mendes Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3833 Eaves Lane Bowie Maryland 20716

20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) June 11, 1999
Lakemont Memorial Gardens
20c. Location - City or Town, State Davidsonville Maryland

21. Signature of Funeral Service Licensee *Fold Miller*
22. Name and Address of Facility Robert E. Evans Funeral Home, Inc.
16000 Annapolis Rd. Bowie Maryland 20715

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Colon Cancer With Metastasis
Due to (or as a consequence of):
b. Hypoproteinemia 2° to liver metastasis.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Thrombophlebitis, bilateral legs.
23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier *Yeartwon H. Yoon M.D.*
29c. License number D14905
29d. Date signed (Month, Day, Year) 6/9/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
YEARTWON H. YOON, 7307 Baltimore Ave. # 111, College Park, Md. 20740

31. Date filed (Month, Day, Year) JUN 10 1999
32. Registrar's Signature *James B. Sparks*

State
Registrar

MENDES, FRANCISCO
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

AH 8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18579

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) <i>Sylvia Payne</i>				2. Date of Death Month <i>June</i> Day <i>5</i> Year <i>1999</i>		3. Time of Death <i>6:00 p.m.</i>	
4a. Facility Name (If not institution, give street and number) <i>Mariner Health Care</i>				4b. City, Town, or Location of Death <i>Laurel</i>		4c. County of Death <i>Prince George's</i>	
5. Social Security Number <i>212-26-4535</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>68</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Feb. 3, 1931</i>	
9. Birthplace (State or Foreign Country) <i>Maryland</i>							
10a. State <i>Maryland</i>		10b. County <i>Howard</i>		10c. City, Town or Location <i>Columbia</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>5776 Sweetwind Place</i>				10f. Zip Code <i>21045</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) <i>12th Grade</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Clerical Worker</i>		16b. Kind of Business/Industry <i>Social Security Administration</i>	
17. Father's Name (First, Middle, Last) <i>LeRoy Brown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Alveta Hall</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Lewis Payne - son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5776 Sweetwind Place Columbia, Maryland 21045</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion Cemetery</i>		20c. Date <i>6/11</i>		20d. Location - City or Town, State <i>Landsdowne Maryland</i>	
21. Signature of Funeral Service Licensee <i>Kevin Parker</i>				22. Name and Address of Facility <i>Kevin A. Parker Funeral Home 3572 Frederick Ave. Baltimore, MD. 21229</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>cerebral vascular accident weeks</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Myocardial infarction</i> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>N. J. ... MD.</i>		29c. License number <i>1541978</i>		29d. Date signed (Month, Day, Year) <i>6-8-99</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>N. J. ... MD. 20785</i>							
31. Date filed (Month, Day, Year) <i>JUN 10 1999</i>				32. Registrar's Signature <i>B. Sparks</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23b or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principles of wave mechanics.

The second part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of matter. It is shown that the theory of the structure of the atom can be used to explain the properties of matter, and that the properties of matter can be used to determine the structure of the atom.

The third part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of light. It is shown that the theory of the structure of the atom can be used to explain the properties of light, and that the properties of light can be used to determine the structure of the atom.

The fourth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of heat. It is shown that the theory of the structure of the atom can be used to explain the properties of heat, and that the properties of heat can be used to determine the structure of the atom.

The fifth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of sound. It is shown that the theory of the structure of the atom can be used to explain the properties of sound, and that the properties of sound can be used to determine the structure of the atom.

The sixth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of electricity. It is shown that the theory of the structure of the atom can be used to explain the properties of electricity, and that the properties of electricity can be used to determine the structure of the atom.

The seventh part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of magnetism. It is shown that the theory of the structure of the atom can be used to explain the properties of magnetism, and that the properties of magnetism can be used to determine the structure of the atom.

The eighth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the universe. It is shown that the theory of the structure of the atom can be used to explain the properties of the universe, and that the properties of the universe can be used to determine the structure of the atom.

The ninth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the human body. It is shown that the theory of the structure of the atom can be used to explain the properties of the human body, and that the properties of the human body can be used to determine the structure of the atom.

The tenth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the human mind. It is shown that the theory of the structure of the atom can be used to explain the properties of the human mind, and that the properties of the human mind can be used to determine the structure of the atom.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18580

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth C. Carr Payne				2. Date of Death Month Day Year June 08 1999				3. Time of Death 7:00pm														
	4a. Facility Name (If not institution, give street and number) Genesis Elder Care- Heritage				4b. City, Town, or Location of Death Dundalk				4c. County of Death n/a														
Funeral Director	5. Social Security Number 488-18-2843		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 9-16-1915		9. Birthplace (State or Foreign Country) Missouri														
	Usual Residence of Decedent																						
To Be Completed by Funeral Director	10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No														
	10e. Street and Number 207 S. Highland Avenue				10f. Zip Code 21224		10g. Citizen of What Country? USA																
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: American Indian															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (14 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress				16b. Kind of Business/Industry Councilman's Restuarant																
	17. Father's Name (First, Middle, Last) Ellahue Pullen				18. Mother's Name (First, Middle, Maiden Surname) Arto (Unk)																		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) daughter Estell Wiencke				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 S. Highland Ave., Baltimore, Md. 21224																		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount		Date 6/10/99		20c. Location - City or Town, State Baltimore, Maryland																
	21. Signature of Funeral Service Licensee ► <i>Marco A. Zannino</i>				22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm 263 S. Conkling St., Baltimore, Md. 21224																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																						
<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. ATRIAL FIBRILLATION</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. CONGESTIVE HEART FAILURE</td> <td>Due to (or as a consequence of):</td> <td>unknown</td> </tr> <tr> <td>c. BIPOLAR DISORDER</td> <td>Due to (or as a consequence of):</td> <td>unknown</td> </tr> <tr> <td>d. FRACTURE OF HIP LEFT</td> <td>Due to (or as a consequence of):</td> <td>5/29/99 at 6:15 PM</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. ATRIAL FIBRILLATION	Due to (or as a consequence of):	Approximate Interval Between Onset and Death	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CONGESTIVE HEART FAILURE	Due to (or as a consequence of):	unknown	c. BIPOLAR DISORDER	Due to (or as a consequence of):	unknown	d. FRACTURE OF HIP LEFT	Due to (or as a consequence of):	5/29/99 at 6:15 PM
Immediate Cause (Final disease or condition resulting in death)	a. ATRIAL FIBRILLATION	Due to (or as a consequence of):	Approximate Interval Between Onset and Death																				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CONGESTIVE HEART FAILURE	Due to (or as a consequence of):	unknown																				
	c. BIPOLAR DISORDER	Due to (or as a consequence of):	unknown																				
	d. FRACTURE OF HIP LEFT	Due to (or as a consequence of):	5/29/99 at 6:15 PM																				
	<table border="1"> <tr> <td>24a. Was an autopsy performed?</td> <td>24b. Were autopsy findings available prior to completion of cause of death?</td> </tr> <tr> <td>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> </table>										24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?																						
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
<table border="1"> <tr> <td>25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td>27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td>28a. Date of Injury (Month, Day, Year) 5-29-99</td> <td>28b. Time of injury 6:15 PM</td> </tr> <tr> <td>28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred SUNSTROKE</td> </tr> <tr> <td>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Nursing Home</td> <td colspan="2">28f. Location (Street and Number or Rural Route Number, City or Town, State) 7232 Germantown Baltimore MD</td> </tr> </table>										25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year) 5-29-99	28b. Time of injury 6:15 PM	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred SUNSTROKE		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Nursing Home	28f. Location (Street and Number or Rural Route Number, City or Town, State) 7232 Germantown Baltimore MD			
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27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year) 5-29-99	28b. Time of injury 6:15 PM																					
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred SUNSTROKE																						
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<table border="1"> <tr> <td>29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> <td>29b. Signature and title of certifier ► <i>Sarinder K. Tullu M.D.</i></td> <td>29c. License number D27188</td> <td>29d. Date signed (Month, Day, Year) 6/9/99</td> </tr> </table>										29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier ► <i>Sarinder K. Tullu M.D.</i>	29c. License number D27188	29d. Date signed (Month, Day, Year) 6/9/99										
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Sarinder K. Tullu 2 Market Place Baltimore MD 21222</i>																							
<table border="1"> <tr> <td>31. Date filed (Month, Day, Year) JUN 10 1999</td> <td>32. Registrar's Signature <i>Barbara B. Sparks</i></td> </tr> </table>										31. Date filed (Month, Day, Year) JUN 10 1999	32. Registrar's Signature <i>Barbara B. Sparks</i>												
31. Date filed (Month, Day, Year) JUN 10 1999	32. Registrar's Signature <i>Barbara B. Sparks</i>																						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18581

Certificate of Death

Reg. No.

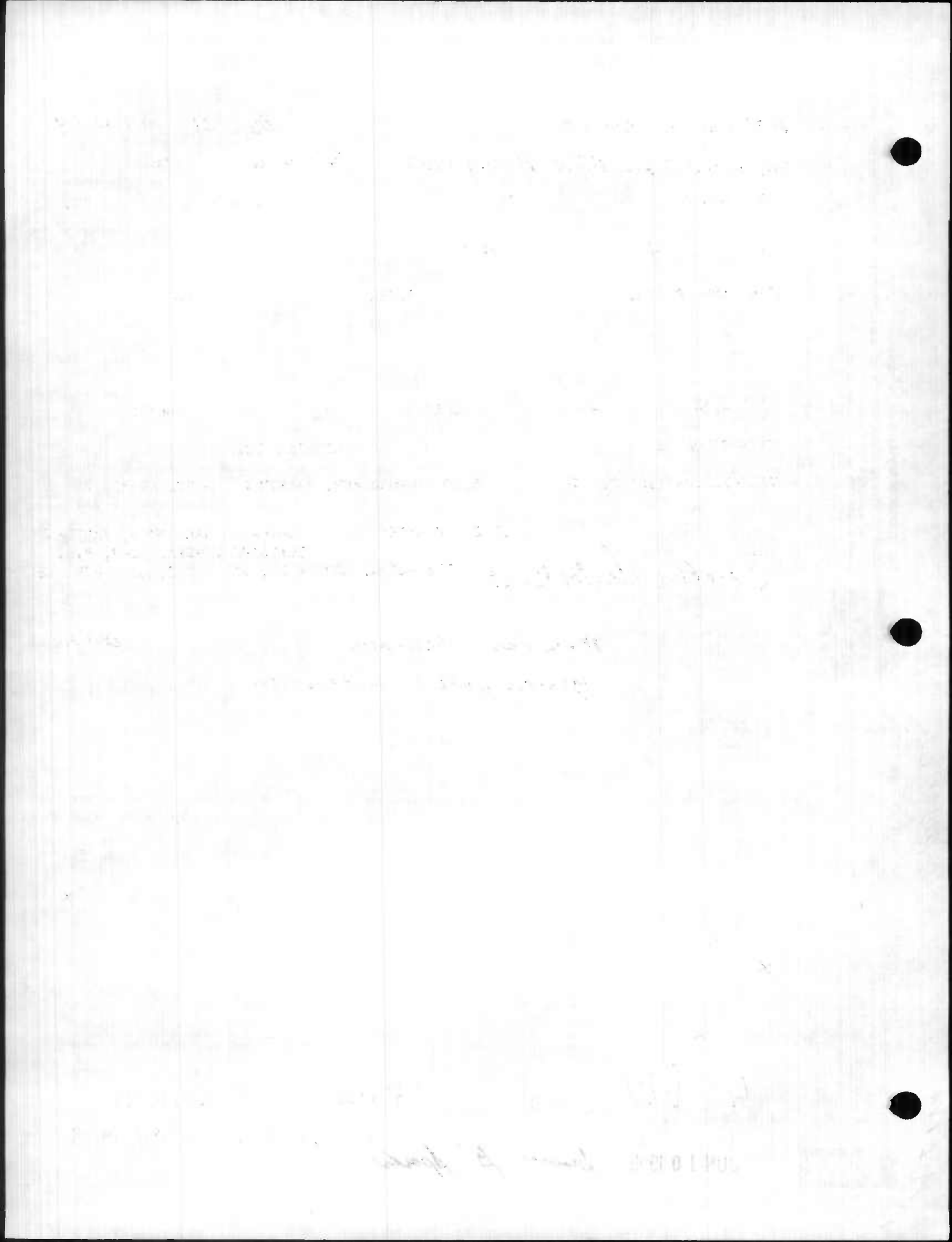
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anthony E Porter				2. Date of Death Month 06 Day 01 Year 99		3. Time of Death 12:20 pm	
	4a. Facility Name (If not institution, give street and number) Baltimore Veterans Affairs Medical Center				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-22-7886		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5-20-28	9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent							
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 5536 MIDWOOD AVE.				10f. Zip Code 21212		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4or 5+) -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRIVER			16b. Kind of Business/Industry HOTEL	
17. Father's Name (First, Middle, Last) VERNON PORTER				18. Mother's Name (First, Middle, Maiden Surname) LILLIAN NEAL				
19a. Informant's Name/Relationship (Type, Print) VALERIE CORNISH(COUSIN)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5536 MIDWOOD AVE. BALTIMORE, MARYLAND 21212				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		Date 6-10-99		20c. Location - City or Town, State BALTIMORE, MARYLAND		
21. Signature of Funeral Service Licensee Deetta Hector CFSP				22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 n. MONROE ST. BALTIMORE, MARYLAND 21217				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. mesenteric ischemia Due to (or as a consequence of): b. gastric outlet obstruction Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death one hour
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Daniel Weiner MD				29c. License number P 12507		29d. Date signed (Month, Day, Year) 06/10/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Daniel Weiner, MD 23 S Greene St N3E09 Baltimore, MD 21201								
31. Date filed (Month, Day, Year) JUN 10 1999				Registrar's Signature [Signature]				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18582

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GERALD PALMER				2. Date of Death Month 06 Day 04 Year 99		3. Time of Death 5:45 AM		
	4a. Facility Name (If not institution, give street and number) LEVINDALE HEBREW GERIATRIC CENTER				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-28-7881		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC 31 1931	9. Birthplace (State or Foreign Country) VIRGINIA	
	Usual Residence of Decedent								
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 14 BROOKSHIRE DRIVE				10f. Zip Code 21136		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LONGSHOREMAN			16b. Kind of Business/Industry TRADE		
17. Father's Name (First, Middle, Last) LLOYD PALMER				18. Mother's Name (First, Middle, Maiden Surname) NANCY GREEN					
19a. Informant's Name/Relationship (Type, Print) Stephanie Palmer/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Brookshire Drive, Baltimore, Maryland 21136					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY		Date 6-9-99		20c. Location - City or Town, State WOODLAWN, MARYLAND			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE RENAL DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PERIPHERAL VASCULAR DISEASE ACQUIRED IMMUNODEFICIENCY SYNDROME Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death 2 YEARS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE ACQUIRED IMMUNODEFICIENCY SYNDROME						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 050164		29d. Date signed (Month, Day, Year) 06/04/99			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LIFE MATHEWS, MD 3424 West Belvedere AVE MO 21215									
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 							

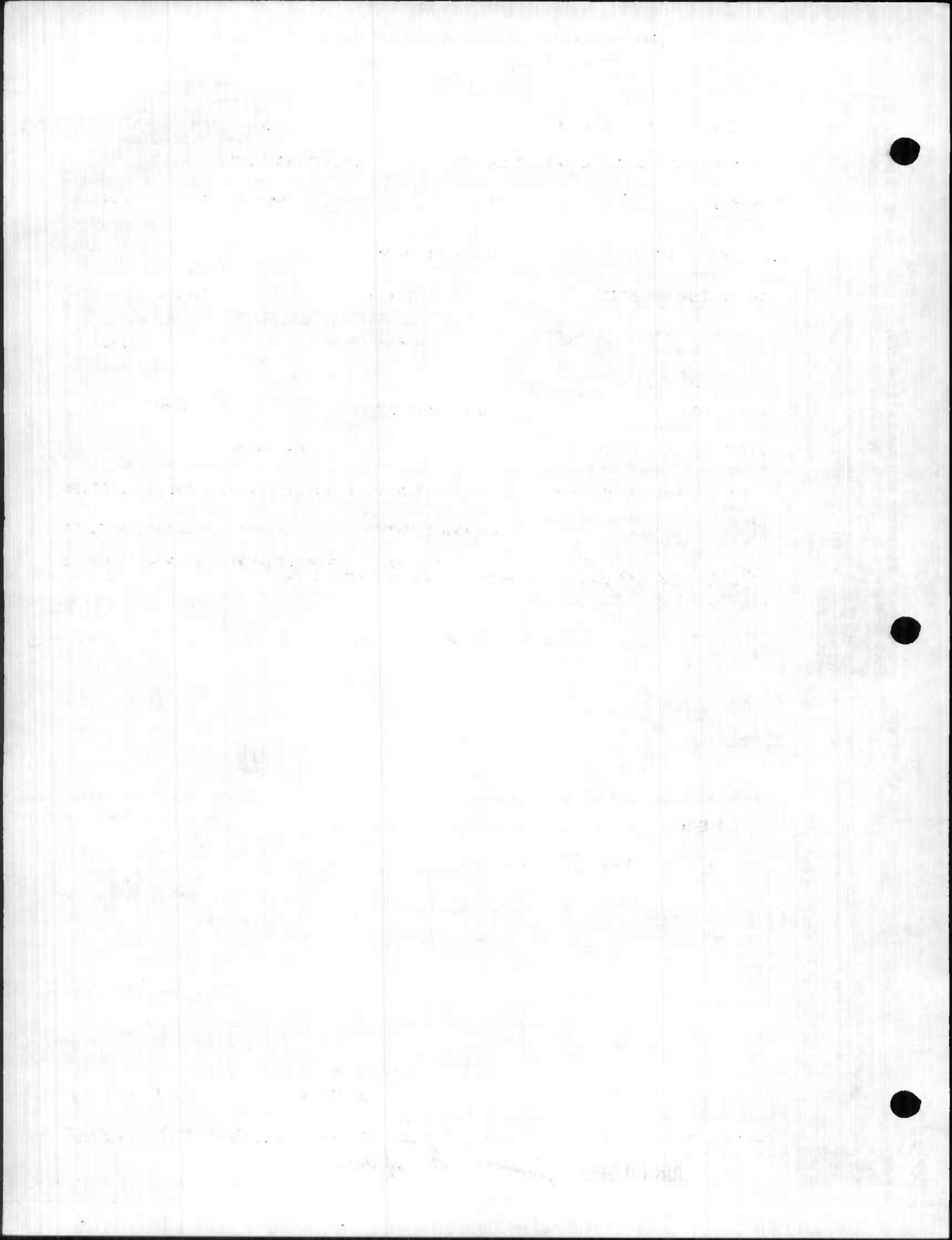
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18583

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Stanley Roguski, Sr.

2. Date of Death

Month Day Year

June 7 1999 6:16 am

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

218-22-9426

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 15, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4431 Medolyn Road

10f. Zip Code

21128

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates

Korean Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steelworker

16b. Kind of Business/Industry

Steel Company

17. Father's Name (First, Middle, Last)

Waclaw Roguski

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Powsniatowska

19a. Informant's Name/Relationship (Type, Print)

Mrs. Anne V. Roguski (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4431 Medolyn Road, Perry Hall, MD 21128

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph Church Cem.

Date

6/11/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

M. T. 33

22. Name and Address of Facility

Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Robert Duncan

29c. License number

D28136

29d. Date signed (Month, Day, Year)

6-8-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Robert Duncan, 615 W. MacPhail Rd., Bel Air, MD 21014

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4x1

99-3241-005

crn

Danny Roche

ITEMS: #23 PART I, 27, 28A-FG PER MEO G772 6-16-99 WR. **Certificate of Death**

Reg. No.

99 18584

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

DANNY RICHARD ROCHE

2. Date of Death
Month Day Year
June 08, 1999
3. Time of Death
6:35 A.M.

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-88-4805

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN 1, 1961

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6917 Richarts Avenue

10f. Zip Code

21244

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5th Grade

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Charles Joseph Roche

18. Mother's Name (First, Middle, Maiden Summa)

Ameila Spindle

19a. Informant's Name/Relationship (Type, Print)

Ameila M. Roelecke (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6917 Richarts Avenue - Baltimore, Maryland 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cemetery

Date

6/12/99

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Quanta R Thomas

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue-Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

NARCOTIC INTOXICATION

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day Year)

6-8-99

28b. Time of Injury

UNKNOWN

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6917 RICHARTS AVE.

BALTIMORE CO., MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. A. Locke MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 09, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. A. Locke MD

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18585

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE MARIE SCHOLLIAN

2. Date of Death
Month Day Year

JUNE 2 1999

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

220-36-3825

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 9 1925

9. Birthplace (State or Foreign Country)

ENGLAND

Usual Residence of Decedent

10a. State
Md.

10b. County

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3444 ELMLEY AVE.

10f. Zip Code

21213

10g. Citizen of What Country?

ENGLAND

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

ARNOLD SCHOLLIAN, JR.

SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3019 ORLANDO AVE. BALTIMORE MD. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MORELAND MEMORIAL PARK

Date

JUNE 5 1999

20c. Location - City or Town, State

BALTIMORE MARYLAND

21. Signature of Funeral Service Licensee

Kendra L. Wells

22. Name and Address of Facility

EVANS FUNERAL CHAPEL
8800 HARTFORD ROAD BALTIMORE, MD 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cervical Cancer
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Tariq Mahmood

29c. License number

D43725

29d. Date signed (Month, Day, Year)

6/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood 2300 Dulany Valley Rd. Timonium, MD 21093

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18586

ITEM: #11 PER INFORMANT G772 6-15-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Horace Simms				2. Date of Death Month 6 Day 8 Year 99		3. Time of Death 12:20 AM	
	4a. Facility Name (If not institution, give street and number) Franklin Woods Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 229-16-8514		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7/12/21	9. Birthplace (State or Foreign Country) VA
	Usual Residence of Decedent							
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location TURNERS STATION			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 526 MAIN STREET				10f. Zip Code 21222		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER			16b. Kind of Business/Industry BETH STEEL	
17. Father's Name (First, Middle, Last) CHARLES SIMMS				18. Mother's Name (First, Middle, Maiden Surname) BETSI JOHNSON				
19a. Informant's Name/Relationship (Type, Print) BESSIE SIMMS BROWN/ DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 SHERWOOD AVENUE, BALTO., MD. 21239				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD. NATIONAL Cemetery		Date 6/12/99		20c. Location - City or Town, State Laurel, MD.
21. Signature of Funeral Service Licensee James A. Morton				22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217				
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MULTIPLE MYELOMA a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 3 MONTHS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC & HYPERTENSIVE CARDIO-VASCULAR DISEASE								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier James A. Morton JMD		29c. License number 015022		29d. Date signed (Month, Day, Year) 6/8/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8552 PHILADELPHIA ROAD, BALTIMORE, MD 21237								
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

jhm

DARRIUS

SIMMONS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO G774

Certificate of Death

Reg. No.

99 18587

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Darrius

Simmons

2. Date of Death

Month

Day

Year

JUNE 06,

1999

3. Time of Death

07:35 AM

4a. Facility Name (If not institution, give street and number)

5528 LIVINGSTON TERRACE

4b. City, Town, or Location of Death

Oxon Hill

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

unk

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

4

16

8. Date of Birth

(Month, Day, Year)

01/20/99

9. Birthplace (State or Foreign Country)

md

Usual Residence of Decedent

10a. State

Md

10b. County

Prince George

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5528 Livingston Ter.

10f. Zip Code

20745

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

INFANT

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INFANT

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

DARREN SIMMONS, SR.

18. Mother's Name (First, Middle, Maiden Surname)

TERRESSA GARDNER

19a. Informant's Name/Relationship (Type, Print)

ANITA DELVISON/GRANDMOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5528 LIVINGSTON TER. OXON HILL, MD. 20745

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

6/12/99 BALTO., MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JAMES A. MORTON & SONS F. H., INC.

1701 LAURENS STREET BALTO., MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SUDDEN INFANT DEATH SYNDROME

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JUNE 07, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

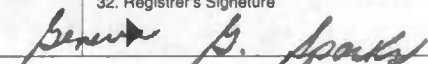
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18588

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RALPH ARNOLD STEVENS				2. Date of Death Month JUNE Day 6 Year 1999		3. Time of Death 7:26 PM	
	4a. Facility Name (If not institution, give street and number) JOSEPH RICHEY HOUSE HOSPICE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216 66 6374	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 4, 1956		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Harford		10c. City, Town or Location Street			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3553 Mill Green Rd.				10f. Zip Code 21154		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer / Machine Operator			16b. Kind of Business/Industry Construction	
17. Father's Name (First, Middle, Last) (Unknown)				18. Mother's Name (First, Middle, Maiden Surname) Annie Marie Blickenstaff				
19a. Informant's Name/Relationship (Type, Print) Evelyn Kinder / Aunt				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3553 Mill Green Rd., Street, MD 21154				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory			Date 6/8/99		20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CARCINOMA OF THE COLON WITH METASTASES YEARS Due to (or as a consequence of): f. GARDNER'S SYNDROME YEARS Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) HOSPICE						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier  JOHN MACGIBBON MD 101 W READ ST						
		29c. License number D06933		29d. Date signed (Month, Day, Year) 06/07/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN MACGIBBON MD 101 W READ ST BALTIMORE MD 21201								
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, 726

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18589

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Selma Rose Stein</i>				2. Date of Death Month Day Year <i>June 4 1999</i>		3. Time of Death <i>7:15 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Futurecare Cherrywood</i>				4b. City, Town, or Location of Death <i>Reisterstown</i>		4c. County of Death <i>Baltimore</i>		
Funeral Director	5. Social Security Number <i>218-12-7431</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>74</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>APR. 25, 1925</i>		
	10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOUSEWIFE</i>		16b. Kind of Business/Industry <i>OWN HOME</i>			
17. Father's Name (First, Middle, Last) <i>SIMON B. HACKERMAN</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>ESTHER LEWIS</i>					
19a. Informant's Name/Relationship (Type, Print) <i>CANTOR ALFRED STEIN / HUSBAND</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3809 CLARKS LANE #207 - BALTIMORE, MD 21215</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>ARLINGTON CHIZUK AMUNO</i>		20c. Location - City or Town, State <i>BALTIMORE, MD</i>		20d. Date <i>6/6/99</i>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. atherosclerotic cardiovascular disease</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. 5 years</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i>				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month/Day/Year) <i>N/A</i>		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D15872</i>		29d. Date signed (Month, Day, Year) <i>June 4 1999</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>HAROLD BUB 25 MARY ST. 21136 REISTERSTOWN MD.</i>									
31. Date filed (Month, Day, Year) <i>JUN 10 1999</i>				32. Registrar's Signature <i>[Signature]</i>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18590

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte Woodruff Skinner

2. Date of Death

Month Day Year
JUNE 6 1999

3. Time of Death

2:00 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

216-30-6329

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
Sept. 24, 1905

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

830 W. 40th St.

10f. Zip Code

21211

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Albert Cook Woodruff

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Crandal

19a. Informant's Name/Relationship (Type, Print)

Robert S. Skinner, Jr./son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

614 Hastings Rd. Towson, MD 21286

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

6/9/99

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

John D. Mitchell

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd.
Baltimore, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metabolic acidosis

Due to (or as a consequence of):

b. bowel ischemia

Due to (or as a consequence of):

c. aspiration pneumonia

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 hour

1 day

1 day

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. A. W. MD

29c. License number

D52096

29d. Date signed (Month, Day, Year)

6/6/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

UTZschneider 63MIL

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

Geneva B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

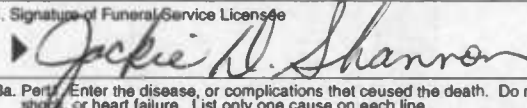
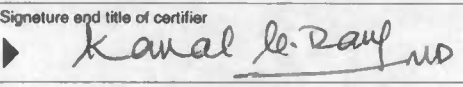

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18591

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH MARY SCHMITT				2. Date of Death Month Day Year JUNE 5 1999		3. Time of Death 7:15 P.M.	
	4a. Facility Name (If not institution, give street and number) St. Martins Home for the aged				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore Co.	
Funeral Director	5. Social Security Number 216-14-0276	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APRIL 10, 1912		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 601 MAIDEN CHOICE LANE				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TYPIST & FILE CLERK			16b. Kind of Business/Industry INSURANCE	
17. Father's Name (First, Middle, Last) ADAM SCHMITT				18. Mother's Name (First, Middle, Maiden Surname) FRANCES WALDHAUSER				
19a. Informant's Name/Relationship (Type, Print) MOTHER MARGUERITE KEMP				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 MAIDEN CHOICE LANE-CATONSVILLE, MARYLAND 21228				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOST HOLY REDEEMER CEM		Date 6/9/99		20c. Location - City or Town, State BALTIMORE, MARYLAND		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME Baltimore, MD 21229 4107 Wilkens Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. WELL - DIFFERENTIATED LYMPHOMA 3 YRS. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RIGHT STROKE PNEUMONIA, HYPOTHYROIDISM ACUTE ON CHRONIC RENAL FAILURE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D18362		29d. Date signed (Month, Day, Year) June, 6, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Komal Dang 3455 Wilkens Avenue SUITE 308, Baltimore, Maryland 21229								
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18592

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN SMOLAK

2. Date of Death

Month
JuneDay
3Year
1999

3. Time of Death

5:15 p.m.

4a. Facility Name (If not institution, give street and number)

CHURCH HOME HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-28-7334

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Jan. 1, 1914

9. Birthplace (State or Foreign Country)

UKRAINE

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

733 S. CURLEY STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

MONARCH RUBBER CO.

17. Father's Name (First, Middle, Last)

OLEKSA SMOLAK

18. Mother's Name (First, Middle, Maiden Surname)

MALANKA ZAZULAK

19a. Informant's Name/Relationship (Type, Print)

ANNA SMOLAK/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

733 S. CURLEY STREET, BALTIMORE, MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ST. MICHAEL'S UKRAINIAN 6/7/99

Date

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY & ZEILER INC. FUNERAL HOME

1901 EASTERN AVENUE, BALTIMORE, MD. 21231

Physician
/Medical
Examiner23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Acute myocardial infarction

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

hours

b. Diabetes mellitus

Due to (or as a consequence of):

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Infected decubitus ulcers

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D08358

29d. Date signed (Month, Day, Year)

6/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gracito V. Patricio, M.D.P.A., 703 S. Clinton Street, Baltimore, Md. 21224

State
Registrar

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18593

Certificate of Death

Reg. No.

Mary Tate
Baltimore, Maryland 21215-0020

AA2

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY TATE				2. Date of Death Month Day Year June 6, 1999				3. Time of Death 16:10	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore City				4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-68-4064		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) 10-7-57		9. Birthplace (State or Foreign Country) BALTIMORE	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 3319 W. GARRISON AVE				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED				16b. Kind of Business/Industry HOUSE MOTHER			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) KARI TATE				18. Mother's Name (First, Middle, Maiden Surname) MARY TATE					
	19a. Informant's Name/Relationship (Type, Print) NICOLE TATE/YANEZ GRAY CHILDREN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3319 W. GARRISON AVE, BALTO. MD 21215					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		Date 6-10-99		20c. Location - City or Town, State BALTO. MD			
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Human Immunodeficiency									
	Immediate Cause (Final disease or condition resulting in death) a. Disseminated Virus Infection unknown									
	Due to (or as a consequence of): b. Acquired Immunodeficiency Syndrome									
	Due to (or as a consequence of): c. d.									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier [Signature] Internal Medicine Resident				29c. License number AS2402321-9493				29d. Date signed (Month, Day, Year) June 6, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ugochi Erondue, MD, PhD, Sinai Hospital of Baltimore									
	31. Date filed (Month, Day, Year) JUN 10 1999									
State Registrar	32. Registrar's Signature [Signature]									

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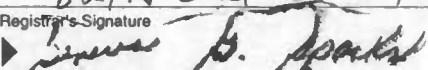
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18594

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raphael Terry				2. Date of Death Month 06 Day 04 Year 99		3. Time of Death 8:15 A.M.	
	4a. Facility Name (If not institution, give street and number) GREENSPRING NURSING CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 216-34-6956		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09/10/1939	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 149 South East Avenue				10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder		16b. Kind of Business/Industry Construction		
17. Father's Name (First, Middle, Last) Kassie Terry				18. Mother's Name (First, Middle, Maiden Surname) Ardella Shannon				
19a. Informant's Name/Relationship (Type, Print) Keith Terry / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 149 South East Ave., Baltimore, Maryland 21224				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State Handstown, Md.		20d. Date 6/11/99
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility The Derrick C. Jones Funeral Hm., 4611 Park Heights Ave., Baltimore, Maryland 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of Lung Due to (or as a consequence of): b. Pleural Effusion Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D47405		29d. Date signed (Month, Day, Year) 6/5/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIQAT ALI 821 N-Entow Street Baltimore MD 21201								
31. Date filed (Month, Day, Year) JUN 10 1999				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18595

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothea Elizabeth Walter				2. Date of Death Month Day Year June 8, 1999		3. Time of Death 8:55 PM		
	4a. Facility Name (If not institution, give street and number) Genesis Heritage Meridian Eldercare				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 220-12-7083	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 6, 1919		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 7237 Martell Avenue				10f. Zip Code 21222		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Banking			16b. Kind of Business/Industry Banking Industry		
17. Father's Name (First, Middle, Last) Walter Hollor Solloway				18. Mother's Name (First, Middle, Maiden Surname) Mary L. Schlinkman					
19a. Informant's Name/Relationship (Type, Print) Husband Mr. Donald Walter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7237 Martell Avenue Dundalk, Maryland 21222					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 6/12/1999		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC COLON CARCINOMA Due to (or as a consequence of): b. MYASTHENIA GRAVIS Due to (or as a consequence of): c. ATRIAL FIBRILLATION Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 4/89 Unknown Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D27188		29d. Date signed (Month, Day, Year) 6/9/89			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sainder K Tulke 2 Martell Place Baltimore MD 21222									
31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

AT 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18596

AMENDED ITEM #19a PER FH G772 6/10/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HENRY MESHACH WATTS

2. Date of Death
Month Day Year

June 07, 1999

3. Time of Death

0756 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

213-26-8028

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

8. Date of Birth (Month, Day, Year)

04/01/1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3813 Dolfeld Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 5/25/1948 to 5/6/1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Public Parks

17. Father's Name (First, Middle, Last)

Henson Watts

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Johnson

19a. Informant's Name/Relationship (Type, Print)

GERALDINE
Geraldine Watts / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3813 Dolfeld Ave., Baltimore, Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veto Cemetery, 6/14/99 Owings Mills, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

The Derrick C. Jones Funeral Hm.,
4611 Park Heights Ave., Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

months

b. Coronary artery disease

Due to (or as a consequence of):

years

c. Diabetes mellitus, Adult onset

Due to (or as a consequence of):

years

d.

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lactic acidosis, hypertension history,
Peripheral vascular disease, chronic obstructive
pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

P12315

29d. Date signed (Month, Day, Year)

June 07, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dawn Dillman Ewing, MD 2701 W Belvedere Ave Baltimore, MD 21215

31. Date filed (Month, Day, Year)

JUN 10 1999

32. Registrar's Signature

[Signature]

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

ORIGINAL

22 1911 10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

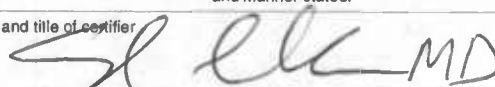
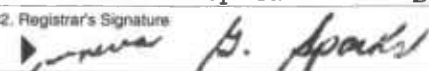
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18597

Certificate of Death

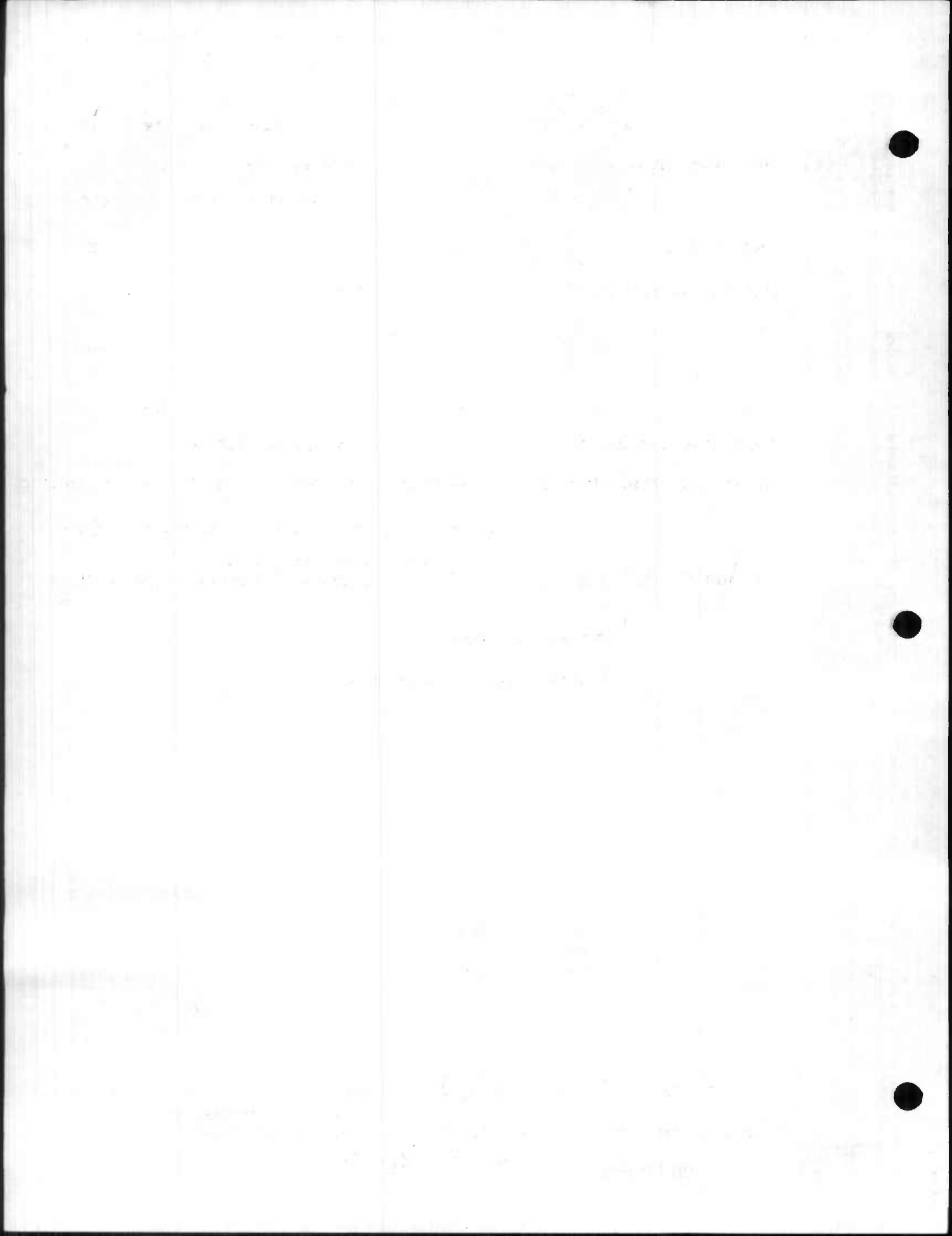
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lance Williams				2. Date of Death Month: June Day: 4 Year: 1999		3. Time of Death 7:00 pm			
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A			
Funeral Director	5. Social Security Number N/A		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. _____		8. Date of Birth (Month, Day, Year) June 4, 1999			
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1946 WEST FAYETTE STREET				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A				
17. Father's Name (First, Middle, Last) GLENN ANTHONY WILLIAMS				18. Mother's Name (First, Middle, Maiden Surname) ARILIA D. WICKHAM						
19a. Informant's Name/Relationship (Type, Print) Arilia D. Wickham (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1946 West Fayette Street - Baltimore, Maryland 21223						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 6/9/99			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue-Baltimore, Maryland 21229						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Extreme prematurity Due to (or as a consequence of): b. Preterm rupture of membranes Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____				Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) N/A		28b. Time of Injury N/A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred N/A		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) N/A				28f. Location (Street and Number or Rural Route Number, City or Town, State) N/A				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  MD					29c. License number P12305	
				29d. Date signed (Month, Day, Year) June 4, 1999						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sharman L. Baybrook, MD Sinai Hospital				2401 W. Belvedere Ave. Balto., MD 21215						
31. Date filed (Month, Day, Year) JUN 10 1999				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

A-41



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18598

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) COLEMAN ELLSWORTH WEBB				2. Date of Death Month Day Year June 07 1999		3. Time of Death 1:35 AM									
	4a. Facility Name (If not Institution, give street and number) St Agnes health care				4b. City, Town, or Location of Death Baltimore		4c. County of Death BALTIMORE COUNTY									
Funeral Director	5. Social Security Number 218-12-3225	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APR 7 1924		9. Birthplace (State or Foreign Country) MARYLAND								
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County BALTIMORE	10c. City, Town or Location CATONSVILLE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	10e. Street and Number 815 WINTERS LANE			10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 43/46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4or 5+) LAB TECH			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LAB TECH		16b. Kind of Business/Industry VA HOSPITAL										
	17. Father's Name (First, Middle, Last) SCOLLIE E. WEBB SR				18. Mother's Name (First, Middle, Maiden Surname) ADA I WEBB											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Thelma I. Webb/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5931 Old Frederick Rd, Catonsville, Md 21228											
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST		Date 6-10		20c. Location - City or Town, State OWINGS MILLS, MARYLAND									
	21. Signature of Funeral Service Licensee <i>Barbara A. Brown</i>				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. <i>End stage COPD</i> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <i>one month</i></td> </tr> <tr> <td>b. <i>pseudomonas tracheobronchitis</i> Due to (or as a consequence of):</td> <td><i>one month</i></td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <i>End stage COPD</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>one month</i>	b. <i>pseudomonas tracheobronchitis</i> Due to (or as a consequence of):	<i>one month</i>	c. _____ Due to (or as a consequence of):		d. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <i>End stage COPD</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>one month</i>														
	b. <i>pseudomonas tracheobronchitis</i> Due to (or as a consequence of):	<i>one month</i>														
	c. _____ Due to (or as a consequence of):															
	d. _____ Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Unstable angina</i> <i>Hypertensive Cardiovascular disease</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Mustapha Mallah M.D.</i>		29c. License number <i>P12595</i>		29d. Date signed (Month, Day, Year) <i>June - 07 - 1999</i>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mustapha Mallah M.D.</i>		<i>900 Caton Avenue Baltimore, MD 21229</i>														
31. Date filed (Month, Day, Year) <i>JUN 10 1999</i>		32. Registrar's Signature <i>[Signature]</i>														

10-11-1950

10-11-1950

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18599

AMEND ITEM #18 PER F.H. G773 7-8-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DENNIS YOUNG, JR.				2. Date of Death Month Day Year June 7 1999		3. Time of Death 12:47 am	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital center				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-54-2539		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4-7-51	9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent							
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 3307 MONDAWMIN AVE.				10f. Zip Code 21216		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4or 5+) -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BARBER			16b. Kind of Business/Industry HAIR CARE	
17. Father's Name (First, Middle, Last) DENNIS YOUNG SR.				18. Mother's Name (First, Middle, Maiden Surname) FLOSSIE REDD RUDD				
19a. Informant's Name/Relationship (Type, Print) BARBARA CORBIN (SISTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 GREENGAGE RD. BALTIMORE, MARYLAND 21244				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		Date 6-12-99		20c. Location - City or Town, State BALTIMORE, MARYLAND		
21. Signature of Funeral Service Licensee <i>Ms. Sumner L. Reed</i>				22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Atherosclerosis Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate interval Between Onset and Death 1 hour
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>William M.D.</i>		29c. License number RD 113720		29d. Date signed (Month, Day, Year) June 7, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Gunta Wheeler, 9000 Franklin Square Drive Baltimore, MD 21237								
31. Date filed (Month, Day, Year) JUN 10 1999				32. Registrar's Signature <i>Spaeth</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

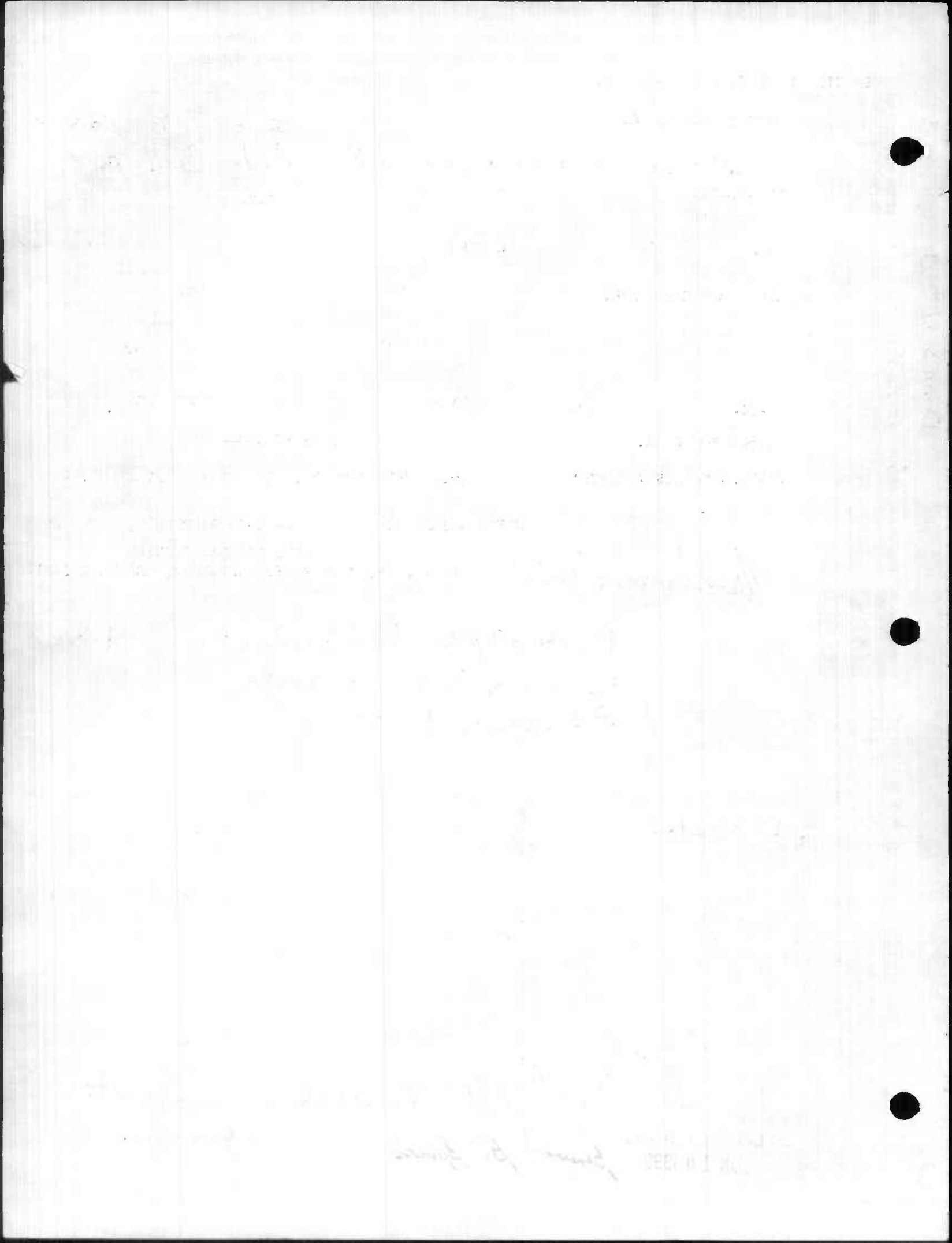
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



99 18600

DHMH 16 Rev 6/95

WRC
99-2952-033
DAMONTAE
APPLEWHITE
ITEMS: #23 PART I, II, 27 PER MEO G772 6-15-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18601

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

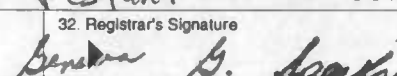
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) DAMONTAE JAQUAIL APPLEWHITE		2. Date of Death Month Day Year MAY 21, 1999		3. Time of Death 8:30 AM.	
4a. Facility Name (If not institution, give street and number) PRINCE GEORGES GENERAL HOSPITAL		4b. City, Town, or Location of Death LANDOVER		4c. County of Death PRINCE GEORGES	
5. Social Security Number 220-53-2252		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days 3 20	
8. Date of Birth (Month, Day, Year) 1-31-1999		9. Birthplace (State or Foreign Country) CHEVERLY, MD			
10a. State MD		10b. County PRINCE GEORGES		10c. City, Town or Location LANDOVER	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 8118 SHERIFF ROAD		10f. Zip Code 20785	
10g. Citizen of What Country? U.S.A.		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A	
17. Father's Name (First, Middle, Last) ANTONIO WALLER		18. Mother's Name (First, Middle, Maiden Surname) DEVONIA APPLEWHITE			
19a. Informant's Name/Relationship (Type, Print) DEVONIA APPLEWHITE -MOTHER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8118 SHERIFF ROAD, LANDOVER, MD 20785			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. OLIVET CEMETERY 6-4-1999		20c. Location - City or Town, State WASHINGTON, DC	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. DC 20001			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TETRALOGY OF FALLOT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 Yes <input type="checkbox"/> No	
28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.	
29d. Data signed (Month, Day, Year) MAY 22, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) JUN 02 1999		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18602

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LIAQAT ALI				2. Date of Death Month Day Year May 22, 1999		3. Time of Death 12:31 P.M.	
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number Unknown		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) 12-6-53	
	9. Birthplace (State or Foreign Country) Pakistan		10a. State Va		10b. County Arlington		10c. City, Town or Location Arlington	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 4400 Lee Hwy #18		10f. Zip Code 22207	
	10g. Citizen of What Country? Pakistan				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Pakistani		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (14 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Taxi Driver				16b. Kind of Business/Industry Taxi Cab			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Ghulam Ali				18. Mother's Name (First, Middle, Maiden Surname) Noor Begum			
	19a. Informant's Name/Relationship (Type, Print) Bilal Khan- Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 Lee Hwy #18, Arlington, Va 22207			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Family Cemetery		20c. Location - City or Town, State Islamabad, Pakistan	
	21. Signature of Funeral Service Licensee <i>Paul de Matos</i>				22. Name and Address of Facility Universal Mortuary Inc. 411 Kennedy St., N.W., Wash, D.C.			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GUNSHOT WOUND OF CHEST Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 5 22 99		28b. Time of Injury 11:38 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28e. Location (Street and Number or Rural Route Number, City or Town, State) 2224 GUSTON ST. P. G. CO MD					
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Harpreet Dhillon MD</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) May 24, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY DANTA KOREN 111 Penn Street, Baltimore, Maryland 21201							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) MAY 25 1999				32. Registrar's Signature <i>[Signature]</i>			
	State Registrar							

ORIGINAL


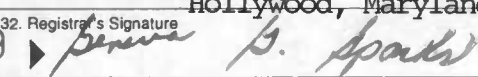
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 18603

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patricia Marx Alldredge				2. Date of Death Month May Day 19 Year 1999				3. Time of Death 7:13 PM		
	4a. Facility Name (If not institution, give street and number) Bayside Care Center				4b. City, Town, or Location of Death Lexington Park				4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 330-20-8657		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) April 23, 1927		9. Birthplace (State or Foreign Country) Iowa		
	Usual Residence of Decedent				10a. State Maryland				10b. County St. Mary's		
10c. City, Town or Location Lexington Park				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 45486 Holly Road				10f. Zip Code 20653				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hostess				16b. Kind of Business/Industry Restaurant			
17. Father's Name (First, Middle, Last) Martin Marx Fulton				18. Mother's Name (First, Middle, Maiden Surname) Anna Winifred Walsh							
19a. Informant's Name/Relationship (Type, Print) Lola Alldredge Herbots, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 Stag Point, San Antonio, Texas 78248							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial Gardens				20c. Location - City or Town, State 5-24-99 Great Mills, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Takoma Funeral Home, Inc. 254 Carroll St. NW, Washington, DC 20012							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of liver Due to (or as a consequence of): b. Cirrhosis of liver Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death about 3 years			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  Dr. M. A. Rahman, MD				29c. License number D50044		29d. Date signed (Month, Day, Year) May 20, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. A. Rahman Hollywood, Maryland 20636				31. Date filed (Month, Day, Year) MAY 25 1999				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18604

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) SOPHIA D. BAKER				2. Date of Death Month Day Year MAY 24 1999		3. Time of Death 6:00 am	
4a. Facility Name (If not institution, give street and number) CROFTON CONVALESCENCY CENTER				4b. City, Town, or Location of Death CROFTON		4c. County of Death ANNE ARUNDEL	
5. Social Security Number 213-30-8177		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	8. Date of Birth (Month, Day, Year) AUG. 28 1915		9. Birthplace (State or Foreign Country) MARYLAND	
Usual Residence of Decedent							
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 33 HICKS AVENUE				10f. Zip Code 21401		10g. Citizen of What Country? US	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LAUNDRY DEPT.		16b. Kind of Business/Industry US NAVAL ACADEMY	
17. Father's Name (First, Middle, Last) WESLEY DAVIS				18. Mother's Name (First, Middle, Maiden Surname) SOPHIA UNOBTAINABLE			
19a. Informant's Name/Relationship (Type, Print) JAMES NEAL (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 BEDFORD RD. SCHENECTADY, NEW Y. 12308			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS		Date 5/27/99		20c. Location - City or Town, State ANNAPOLIS, MD.	
21. Signature of Funeral Service Licensee <i>Larry G. Reese</i>				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number D 38958		29d. Date signed (Month, Day, Year) 5/24/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALJEET SINGH SIDHU 1413 ANNAPOLIS ROAD #106 ODENTON MD 21113							
31. Date filed (Month, Day, Year) MAY 27 1999		32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

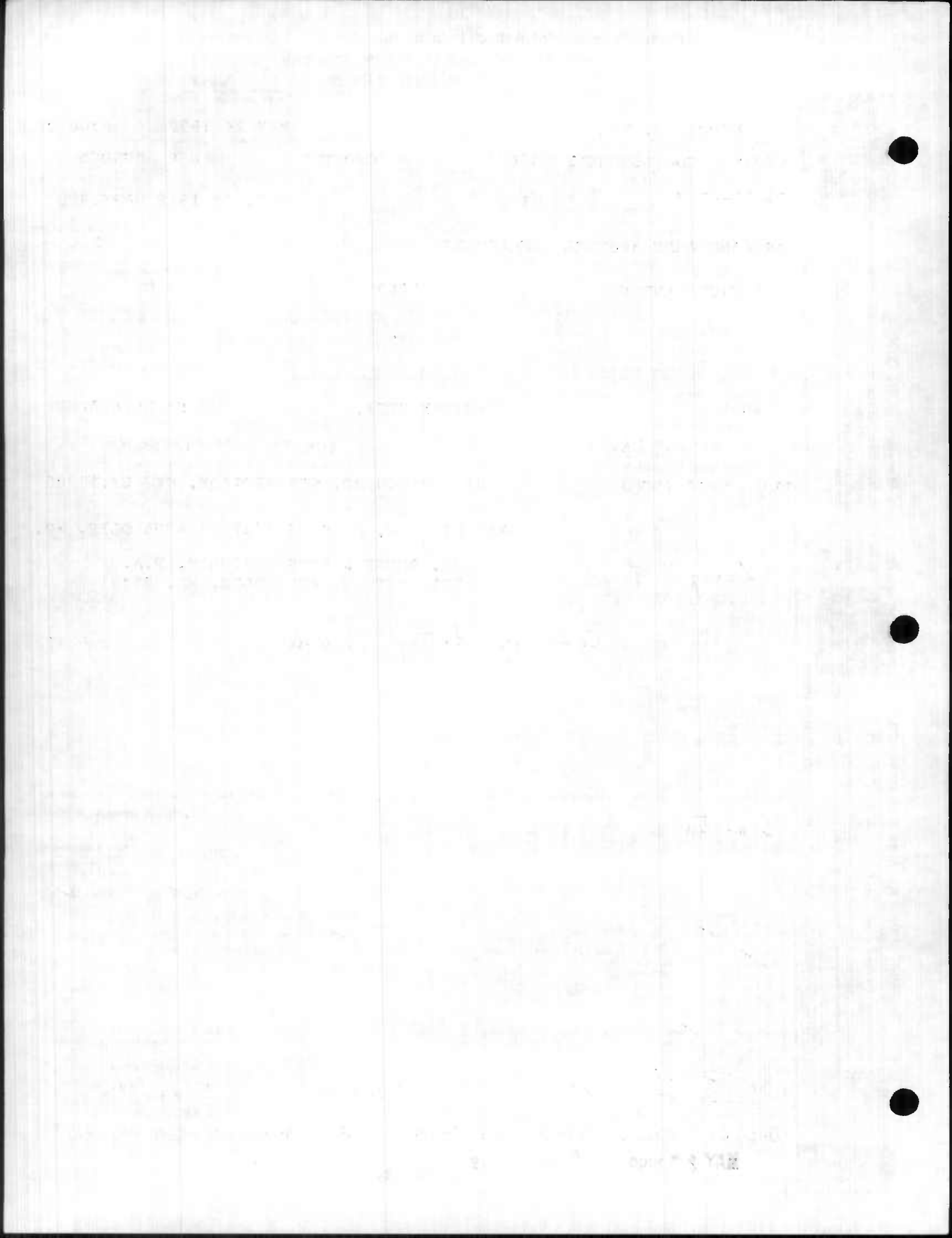
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18605

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IRA ELWOOD BARNES, SR.				2. Date of Death Month Day Year MAY 23, 1999		3. Time of Death 11:30 AM	
	4a. Facility Name (If not institution, give street and number) 3915 SYKESVILLE RD.				4b. City, Town, or Location of Death FINKSBURG		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 216-14-5124		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1/28/1920	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MD.		10b. County CARROLL		10c. City, Town or Location FINKSBURG			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3915 SYKESVILLE RD.				10f. Zip Code 21048		10g. Citizen of What Country? USA.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER			16b. Kind of Business/Industry TRANSPORTATION	
17. Father's Name (First, Middle, Last) JOSHUA LEVERING BARNES					18. Mother's Name (First, Middle, Maiden Surname) EVA MAUD BARNES			
19a. Informant's Name/Relationship (Type, Print) ELEANOR C. BARNES - WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3915 SYKESVILLE RD., FINKSBURG, MD. 21048				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) PROVIDENCE CEMETERY		Date 5/26/99		20c. Location - City or Town, State GAMBER, MD.
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Diabetes Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 25 yrs 2 wks
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D 25443		29d. Date signed (Month, Day, Year) 5 24 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN MIDDLETON 688 Poole Road, Westminster Md 21157								
31. Date filed (Month, Day, Year) MAY 25 1999				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

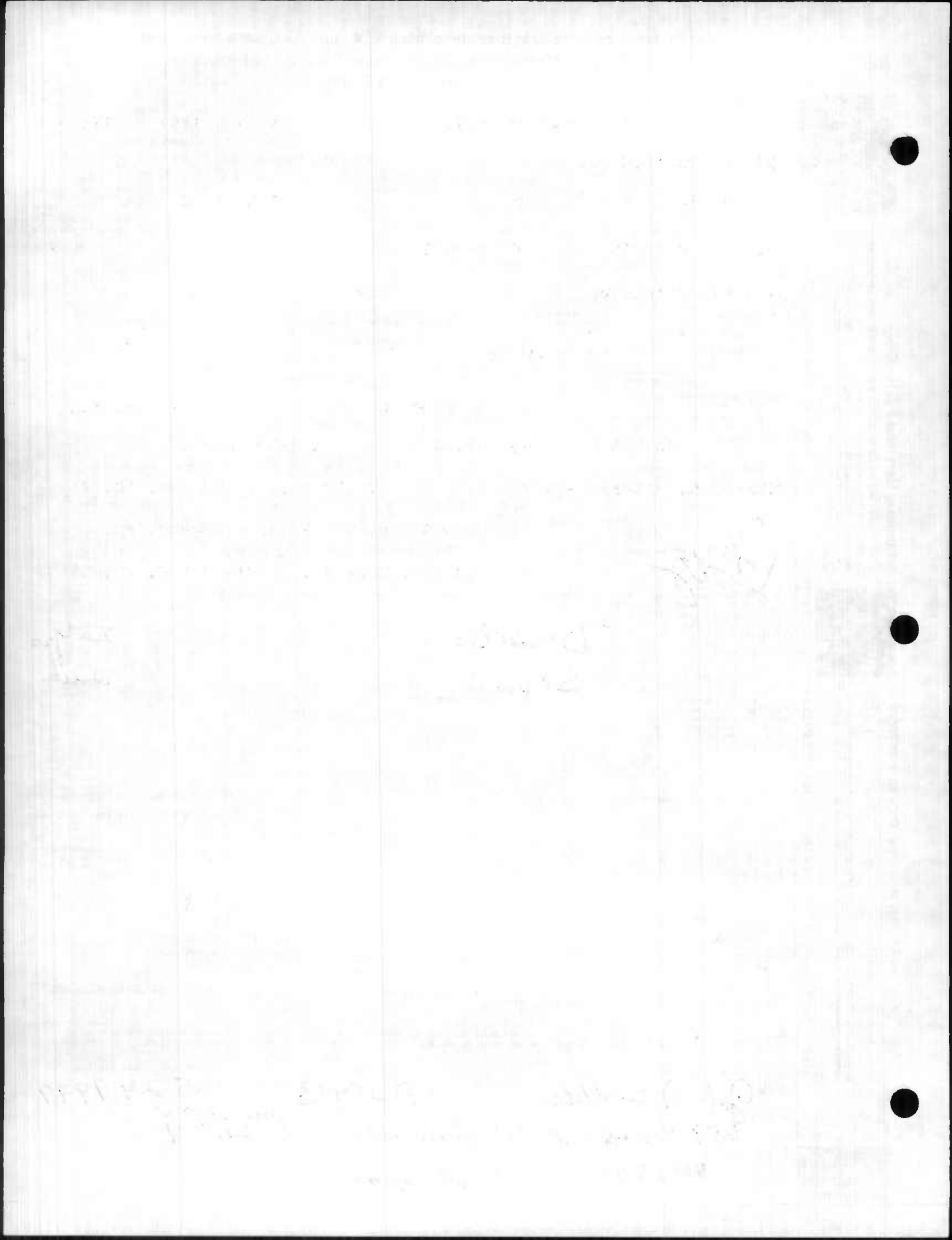
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18606

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HONORABLE WILLIAM EARL BROWN SR				2. Date of Death Month MAY Day 26 Year 1999				3. Time of Death 9:30AM		
	4a. Facility Name (If not institution, give street and number) 404 BIDDLE ST.				4b. City, Town, or Location of Death CHESAPEAKE CITY				4c. County of Death CECIL		
Funeral Director	5. Social Security Number 176-20-1014		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 8, 1910		9. Birthplace (State or Foreign Country) Pa.		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MD.		10b. County CECIL		10c. City, Town or Location CHESAPEAKE CITY				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 360 BIDDLE STREET				10f. Zip Code 21915		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: NAVY WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LIFE UNDERWRITER				16b. Kind of Business/Industry INSURANCE				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) CLARENCE A. BROWN				18. Mother's Name (First, Middle, Maiden Surname) ALICE MACINNIS						
	19a. Informant's Name/Relationship (Type, Print) WILLIAM E. BROWN JR.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 BIDDLE ST CHESAPEAKE CITY, MD 21915						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. MARKS EPISCOPAL		20c. Location - City or Town, State 5/29/99 ELVERSON PA.						
	21. Signature of Funeral Service Licensee Edward J. Brown				22. Name and Address of Facility BEE FUNERAL HOME 259 E. MAIN ST ELKTON MD.						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adenocarcinoma of Liver								Approximate Interval Between Onset and Death 2mos		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. c. d.										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal insufficiency.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier Jose Ma M.D.								
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jose Ma 111 W. High St, Elkton MD. 21921.				29c. License number 044716		29d. Date signed (Month, Day, Year) MAY 26, 1999				
	31. Date filed (Month, Day, Year) MAY 27 1999		32. Registrar's Signature James S. Sparks								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18607

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mae Belle Bryant					2. Date of Death Month Day Year May 24 1999		3. Time of Death 1805 p.m.		
	4a. Facility Name (If not institution, give street and number) Sunrise Care Center					4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil		
Funeral Director	5. Social Security Number 218-16-9957		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 4 1920		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Cecil		10c. City, Town or Location Elkton			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 210 East High Street					10f. Zip Code 21921		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maid			16b. Kind of Business/Industry Hospital			
	17. Father's Name (First, Middle, Last) Daniel Corpening					18. Mother's Name (First, Middle, Maiden Summa) Ethel McGimpsey				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Catherine Dorsey					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 N. Brown Elf Road Newark, DE 19713				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bohemia Manor Cemetery		Data 5/29/99		20c. Location - City or Town, State Chesapeake City, MD			
	21. Signature of Funeral Service Licensee <i>[Signature]</i> K1900457					22. Name and Address of Facility 19805 CONGO FUNERAL HOME 201 N. Gray Ave. Wilm., DE				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CVA Due to (or as a consequence of): b. Metastatic Renal / Colon CA Due to (or as a consequence of): c. CVA Due to (or as a consequence of): d. Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death 4 days
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number 033510-M00860		29d. Date signed (Month, Day, Year) 5/25/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 32 Peoples Plaza Glasgow DE 19702										
31. Date filed (Month, Day, Year) MAY 26 1999					32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18608

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sheila Diana Bush-Plater				2. Date of Death Month Day Year May 24 1999		3. Time of Death 2 55 PM	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 579-72-0791		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 14, 1956	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD.		10b. County Prince Georges		10c. City, Town or Location Temple Hills	
Usual Residence of Decedent								
10a. State MD.			10b. County Prince Georges			10c. City, Town or Location Temple Hills		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 5516 Fisher Road			10f. Zip Code 20748		
10g. Citizen of What Country? United States			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Aid			16b. Kind of Business/Industry National Capitol Park & Planning			17. Father's Name (First, Middle, Last) James Douglas Bush		
18. Mother's Name (First, Middle, Maiden Surname) Mary Smith			19a. Informant's Name/Relationship (Type, Print) Eugene Plater/husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5516 Fisher Road Temple Hills, Maryland 20748		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem.			20c. Location - City or Town, State 5/29/99 Clinton, MD.		
21. Signature of Funeral Service Licensee <i>Prince Edwards</i>			22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill RD. Suitland, MD. 20746					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic Breast Cancer</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i>								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>David Riseberg MD</i>								
29c. License number D40854								
29d. Date signed (Month, Day, Year) May 24, 1999								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID Riseberg 301 St Paul PL Baltimore, MD 21202								
31. Date filed (Month, Day, Year) MAY 27 1999								
32. Registrar's Signature <i>Beverly S. Sparks</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature or scribble.

RECEIVED 1980

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18609

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nettie Katherine Brooks				2. Date of Death Month May Day 20 Year 1999		3. Time of Death 3:44 am	
	4a. Facility Name (If not Institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 223-28-4319		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) April 16 1920	
	9. Birthplace (State or Foreign) Warrenton, Oregon		10a. State Md.		10b. County Prince Georges		10c. City, Town or Location Brentwood	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3728 Rhode Island Avenue		10f. Zip Code 20722-1434		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) James Kirby		
18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) James Kirby		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Margaret Lunceford		
19a. Informant's Name/Relationship (Type, Print) Robert Grady Brooks/Husb.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3728 Rhode Island Avenue Brentwood, Md. 20722				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens		20c. Location - City or Town, State Davidsonville Maryland		20d. Date 05-24-99		
21. Signature of Funeral Service Licensee Shannon W. Ramirez Shannon W. Ramirez M00998				22. Name and Address of Facility BEALL FUNERAL HOME 6512 N.W. Crain Highway Bowie, Md 20715				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) a. CARDIOGENIC SHOCK WITH HYPOTENSION Due to (or as a consequence of): b. ISCHEMIC AND CONGESTIVE CARDIOMYOPATHY Due to (or as a consequence of): c. DIFFUSE CORONARY ARTERY DISEASE Due to (or as a consequence of): WITH PREVIOUS MYOCARDIAL INFARCTION d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① HYPERTENSION ② GERD ③ VALVULAR HEART DISEASE ④ ATRIAL FIBRILLATION ⑤ CONGESTIVE HEART FAILURE ⑥ ATREACTASIS OF RIGHT LOWER LOBE OF LUNG ⑦ DIABETES MELLITUS								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Date signed (Month, Day, Year) 5.20.99		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Mohammed A. Mannan MD		29c. License number D24593		29d. Date signed (Month, Day, Year) 5.20.99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MOHAMMED A. MANNAN M.D., 3331-TOLEDO TERRACE, SUITE 206 HYATTSVILLE, MD. 20782								
31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18610

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SUZANNE MARIE BAGNALL

2. Date of Death

Month Day Year
MAY 20, 1999

3. Time of Death

PM 1701 FOUND

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MCDONALDS PARKING LOT ROUTE 1

4b. City, Town, or Location of Death

COLLEGE PARK

4c. County of Death

PRINCE GEORGES

5. Social Security Number

016-28-0801

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 26, 1931

9. Birthplace (State or Foreign)

Cambridge

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6801 Baltimore Avenue

10f. Zip Code

20740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)Administrative
Support

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Jules P. Chartrand

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Ilda Lally

19a. Informant's Name/Relationship (Type, Print)

John William Bagnall/Husb. 6801 Baltimore Ave. College Park Md. 20740

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Metropolitan
Crematory

Date

05-22-99

20c. Location - City or Town, State

Alexandria
Virginia

21. Signature of Funeral Service Licensee

Shannon W. Ramirez M00798

22. Name and Address of Facility

Beall funeral Home
6512 N.W. Crain Hwy. Bowie, Maryland 2071523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. HYPERTENSIVE CARDIOVASCULAR DISEASE AND

Due to (or as a consequence of):

b. SEIZURE DISORDER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ETHANOL ABUSE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) CAR

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shannon W. Ramirez M00798

29c. License number

D339574

29d. Date signed (Month, Day, Year)

MAY 20, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARCO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State
Registrar

31. Date filed (Month, Day, Year)

MAY 24 1999

32. Registrar's Signature

B. Spivey

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(3)

[Faint, illegible text covering the page, possibly bleed-through from the reverse side. The text is too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18611

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kimberly A. Barry				2. Date of Death Month Day Year MAY 20, 1999				3. Time of Death 2120 PM	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE				4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 212-68-1281	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 26, 1961		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Crofton				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 1761 Sharwood Place				10f. Zip Code 21114		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own home			
	17. Father's Name (First, Middle, Last) William Paul Myers				18. Mother's Name (First, Middle, Maiden Summa) Patricia Warren					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Stephen A. Barry - Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1761 Sharwood Place Crofton, MD 21114					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven		Data May 24, 1999		20c. Location - City or Town, State Silver Spring, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706					
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest following Due to (or as a consequence of): b. Surgical Repair of perforated Due to (or as a consequence of): c. Gastric Ulcer Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatitis C with micronodular Cirrhosis								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
State Registrar	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MAY 22, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAY 24 1999				32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18612

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BOB BALL				2. Date of Death Month Day Year 05 19 99		3. Time of Death 1700		
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY MD		4c. County of Death WICOMICO		
Funeral Director	5. Social Security Number 245-07-3130		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 07-11-12		
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Delaware		10b. County Sussex		10c. City, Town or Location Seaford		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 226 Shipley St		10f. Zip Code 19973		10g. Citizen of What Country? US	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Millwright		16b. Kind of Business/Industry Construction			
17. Father's Name (First, Middle, Last) William Ball				18. Mother's Name (First, Middle, Maiden Surname) Laura Garrett					
19a. Informant's Name/Relationship (Type, Print) Thelma Ball - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 Shipley St., Seaford, DE 19973					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Blades Cemetery		Date 5/23/99		20c. Location - City or Town, State Blades, DE			
21. Signature of Funeral Service Licensee  John A. Cranston		22. Name and Address of Facility Cranston Funeral Home P O Box 967, Seaford, DE 19973							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. ACUTE RENAL FAILURE Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. SUBDURAL HEMATOMA Due to (or as a consequence of): d. FALL AT HOME								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOSCLEROTIC HEART DISEASE WITH ATRIAL FIBRILLATION; CHRONIC OBSTRUCTIVE PULMONARY DISEASE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 05-11-99		28b. Time of Injury 1115 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred FELL AT HOME	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  JOHN T. BULKELEY, M.D.		29c. License number D0003599		29d. Date signed (Month, Day, Year) 05-19-99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801		31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

12

1. The purpose of this document is to provide information regarding the activities of the [redacted] and the [redacted] in the [redacted] area.

2. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

3. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

4. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

5. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

6. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

7. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

8. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

9. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

10. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

11. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

12. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

13. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

14. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

15. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

16. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

17. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

18. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

19. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

20. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

21. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

22. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

23. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

24. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18613

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Allen B. Blount, Sr.

2. Date of Death

May

18

1999

3. Time of Death

10:11 P.M.

4a. Facility Name (If not institution, give street and number)

626 Cedar Street

4b. City, Town, or Location of Death

Pocomoke City

4c. County of Death

Worcester

5. Social Security Number

216-10-7515

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 6, 1913

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10e. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

626 Cedar Street

10f. Zip Code

21851

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
5th

College (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

longshoreman

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Allen Blount

18. Mother's Name (First, Middle, Maiden Surname)

Sallie Honeyblue

19a. Informant's Name/Relationship (Type, Print)

Miriam Golden/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

626 Cedar Street, Pocomoke City, MD 21851

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Trinity UMC Cemetery

Date

5/22/99

20c. Location - City or Town, State

Pocomoke City, MD

21. Signature of Funeral Services Licensee

22. Name and Address of Facility

Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 2180123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Ca. Bladder

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- HTN
- Hemorrhagic Cystitis.
- Cardiac Dysrhythmia.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

53611

29d. Date signed (Month, Day, Year)

5/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5474 Riverside DR, Salisbury, MD 21801

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18614

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Jenny Linea Brown					2. Date of Death May 25 1999		3. Time of Death 12:00AM		
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital					4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 038-42-0329		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87	8. Date of Birth (Month, Day, Year) Aug. 5, 1911	9. Birthplace (State or Foreign Country) Rhode Island				
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 6204 Teaberry Way				10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home					
	17. Father's Name (First, Middle, Last) Iver Johnson					18. Mother's Name (First, Middle, Maiden Surname) Thelma				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Susan E. Weber (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6204 Teaberry Way Clinton, Maryland 20735					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rhode Island Veterans Mem. Cem.		Date Exeter, RI		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton MD 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Renal Failure Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Dr. Scott Kelso				29c. License number D 41580		29d. Date signed (Month, Day, Year) May 27, 1999			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Scott Kelso 2503 SURRAHS RD CLINTON, MD 20735									
	31. Date filed (Month, Day, Year) JUN 01 1999		32. Registrar's Signature B. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18615

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) CLARA BRANCH		2. Date of Death Month MAY Day 29 Year 1999		3. Time of Death 2:50 P.M.
4a. Facility Name (If not institution, give street and number) Mallard Bay Nursing Center		4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester
5. Social Security Number 231-07-9283	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 21, 1900	9. Birthplace (State or Foreign Country) Virginia

10a. State MD	10b. County Dorchester	10c. City, Town or Location Cambridge	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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10e. Street and Number 520 Glenburn Avenue	10f. Zip Code 21613	10g. Citizen of What Country? USA
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11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (14 or 5+)	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Line Worker Canning Factory	16b. Kind of Business/Industry
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17. Father's Name (First, Middle, Last) Austin Branch	18. Mother's Name (First, Middle, Maiden Surname) Annie Spruill
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19a. Informant's Name/Relationship (Type, Print) Gloria Jenkins	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403-A Oakley St. Cambridge, MD. 21613
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20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) East New Market Cemetery	Date 6/03/99	20c. Location - City or Town, State East New Market, MD
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21. Signature of Funeral Service Licensee Janelle C. Henry	22. Name and Address of Facility Henry Funeral Home P.A. 510 Washington St. Cambridge, MD. 21613
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)	a. Serum electrolyte abnormalities	Approximate Interval Between Onset and Death
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Serum crippling arthritis.	years.
	c. Due to (or as a consequence of): Serum dementia.	years
	d. Due to (or as a consequence of): Osteoarthritis.	years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
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24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year) M
28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier	29c. License number D50987	29d. Date signed (Month, Day, Year) 6/11/99
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed Nawaz 105 Amersweet Cambridge	31. Date filed (Month, Day, Year) JUN 2 1999	32. Registrar's Signature B. Sparks	21613.
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State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18616

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Samuel Campbell Chase, Jr.				2. Date of Death Month Day Year May 23, 1999		3. Time of Death 8:00 A.M.		
	4a. Facility Name (If not institution, give street and number) 1229 Glencrest Terrace				4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 217-46-2883		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) Sep. 1, 1946		
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Pasadena		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1229 Glencrest Terrace		10f. Zip Code 21122		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1966-68		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 2 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plant Superintendent		16b. Kind of Business/Industry Construction Materials Company					
17. Father's Name (First, Middle, Last) Samuel Campbell Chase, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary M. Haas					
19a. Informant's Name/Relationship (Type, Print) E. Sue Chase/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1229 Glencrest Terrace Pasadena, MD 21122					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem'l. Gardens		20c. Location - City or Town, State 5-27-99 Davidsonville, MD					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic squamous cell carcinoma of tongue Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death 9 months					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypercalcemia				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Maura L. Gillison M.D.		29c. License number 050498		29d. Date signed (Month, Day, Year) May 24, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maura L. Gillison, M.D. 600 N. Wolfe Street Rm. 124 Oncology Baltimore, MD 21287									
31. Date filed (Month, Day, Year) MAY 27 1999		32. Registrar's Signature 							

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18617

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE J. CARROLL

2. Date of Death

MAY 24 1999

3. Time of Death

0202

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

705-09-6756

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

SEPT. 21 1918

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

CROWNSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1612 CROWNSVILLE ROAD

10f. Zip Code

21032

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

0

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WAREHOUSE FOREMAN

16b. Kind of Business/Industry

FT. GEORGE MEADE

17. Father's Name (First, Middle, Last)

ERNEST CARROLL

18. Mother's Name (First, Middle, Maiden Surname)

MARY ROBINSON

19a. Informant's Name/Relationship (Type, Print)

MAMIE M. CARROLL (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1612 CROWNSVILLE RD. CROWNSVILLE, MD. 21032

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERAN CEME. 5/28/99 CROWNSVILLE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Larry S. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

1 wk

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetic ketoacidosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Larry S. Reese

29c. License number

D38158

29d. Date signed (Month, Day, Year)

5/24/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Lisa A. Dimarzio 2003 Medical Parkway, ANNAPOLIS, MD 21401

State
Registrar

31. Date filed (Month, Day, Year)

MAY 26 1999

32. Registrar's Signature

Beverly B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18618

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Curilla				2. Date of Death Month Day Year May 19, 1999				3. Time of Death 8:00 P.M.	
	4a. Facility Name (If not institution, give street and number) 363 Colony Point Place				4b. City, Town, or Location of Death Edgewater				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 165-18-1446		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) Yrs. 78		8. Date of Birth (Month, Day, Year) May 21, 1920		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Edgewater				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 363 Colony Point Place				10f. Zip Code 21037				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 yr.				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager				16b. Kind of Business/Industry Toyota Corp.		
17. Father's Name (First, Middle, Last) John E. Curilla						18. Mother's Name (First, Middle, Maiden Surname) Mary Janasov				
19a. Informant's Name/Relationship (Type, Print) Vilma F. Curilla/ Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 363 Colony Point Place Edgewater, Maryland 21037					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 5-21-99		20c. Location - City or Town, State Alexandria, Virginia			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sarcoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and Title of Certifier 					29c. License number 019838		29d. Date signed (Month, Day, Year) 5/21/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selovich, M.D. 900 Bestgate Rd. Annapolis, Md.										
31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4379

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18619

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth W. Cross				2. Date of Death Month Day Year May 23, 1999		3. Time of Death 11:45PM	
	4a. Facility Name (If not institution, give street and number) Look About Manor				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 268-16-2588		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) April 22, 1919	
	9. Birthplace (State or Foreign Country) Ohio		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2578 Misty Ridge Cove		10f. Zip Code 21401		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer		16b. Kind of Business/Industry Commercial				
17. Father's Name (First, Middle, Last) William A. Cross				18. Mother's Name (First, Middle, Maiden Surname) Edyth Dunn				
19a. Informant's Name/Relationship (Type, Print) Mary Ellen Cross (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2578 Misty Ridge Cove Annapolis, MD 21401				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		20c. Location - City or Town, State 5/25/99 Brentwood, Maryland				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CVA Due to (or as a consequence of): ASCVD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5 min 10y								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Assisted Living Facility						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred Living Facility				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D25443		29d. Date signed (Month, Day, Year) 5/24/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Middleton, MD. 688C Poole Rd. Westminster, Maryland 21157								
31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #23c & 23b PER ME G823 9/16/03 TH Certificate of Death

Reg. No. 99 18620

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) PATRICK THOMAS CARROLL
2. Date of Death Month Day Year MAY 17, 1999
3. Time of Death 0427

Funeral
Director

4a. Facility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death LAUREL
4c. County of Death PRINCE GEORGES
5. Social Security Number 577-90-9918
6. Sex 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday) 37 Yrs.
8. Date of Birth (Month, Day, Year) JUNE 15, 1961
9. Birthplace (State or Foreign Country) WASHINGTON DC

Usual Residence of Decedent
10a. State MD 10b. County PRINCE GEORGES 10c. City, Town or Location LAUREL 10d. Inside City Limits ☒ Yes 2 ☐ No

10e. Street and Number 13605 AVEBURY DR #21 10f. Zip Code 20708 10g. Citizen of What Country? UNITED STATES

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 Collage (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MGT. RETAIL SALES 16b. Kind of Business/Industry PRIVATE

17. Father's Name (First, Middle, Last) ARTHUR W. CARROLL 18. Mother's Name (First, Middle, Maiden Surname) CATHERINE THOMAS

19a. Informant's Name/Relationship (Type, Print) CATHERINE T. CARROLL / MOTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13605 AVEBURY DR. #21, LAUREL, MD 20708

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND NATONAL CEMETERY 5-21-99 LAUREL, MD
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME 2617 PENN.AVE S.E. WASHINGTON DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of):
b. CARDIOMYOPATHY Due to (or as a consequence of):
c. VIRAL MYOCARDITIS AND ETHANOL ABUSE Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier [Signature] 29c. License number D33954 29d. Date signed (Month, Day, Year) MAY 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year) MAY 24 1999 32. Registrar's Signature [Signature]

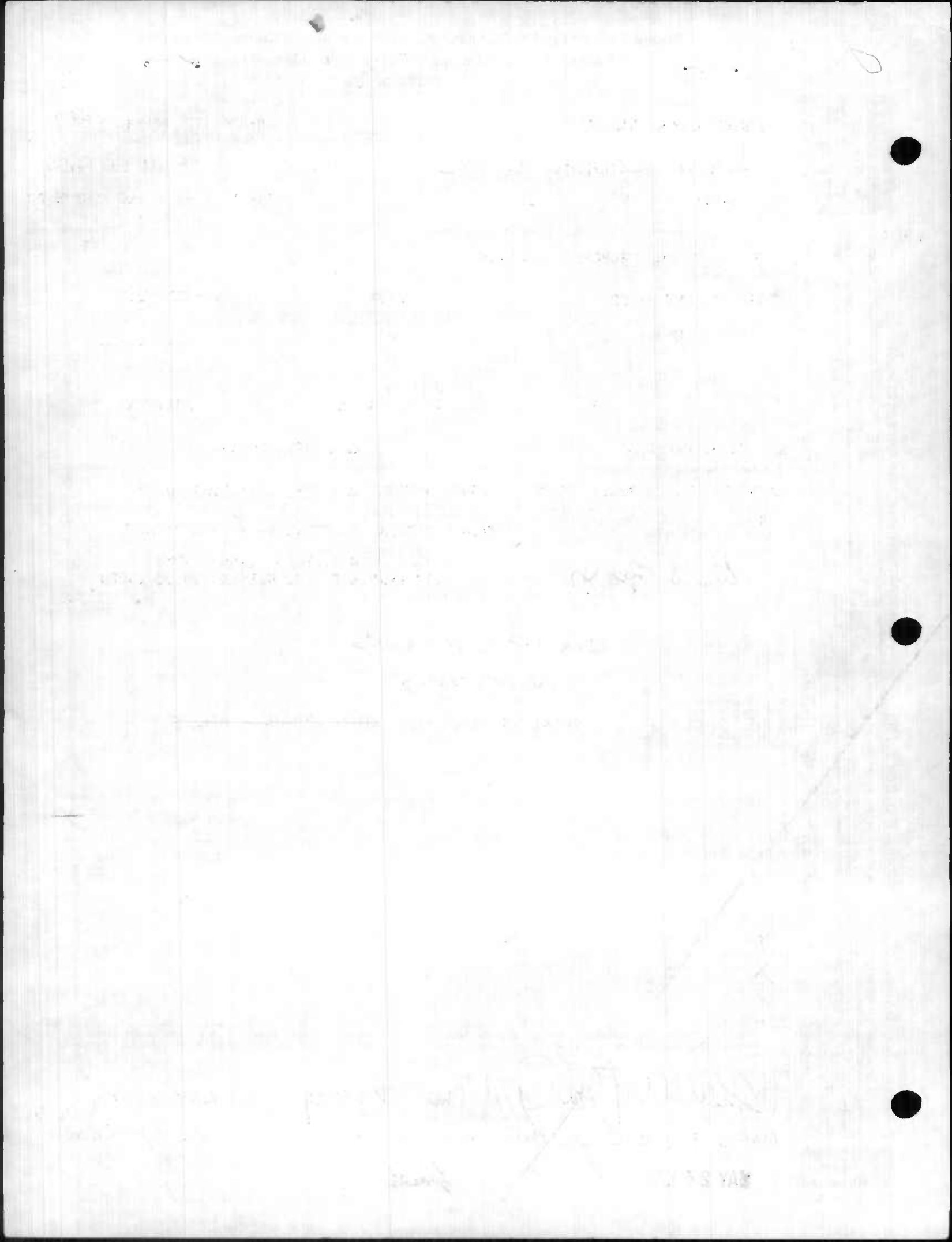
State
Registrar

4 0/4
Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18621

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jasper Rufus Conrad					2. Date of Death Month Day Year May 23 1999			3. Time of Death 8:00 AM			
	4a. Facility Name (If not institution, give street and number) 2121 Bethel Road					4b. City, Town, or Location of Death Finksburg			4c. County of Death Carroll			
Funeral Director	5. Social Security Number 244-14-5801		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Aug 4 1920		9. Birthplace (State or Foreign Country) N.C.			
	Usual Residence of Decedent					10a. State MD		10b. County Carroll		10c. City, Town or Location Finksburg		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					10e. Street and Number 2121 Bethel Road			10f. Zip Code 21048		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) College					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Quality Control			16b. Kind of Business/Industry Black & Decker				
17. Father's Name (First, Middle, Last) Jasper R Conrad					18. Mother's Name (First, Middle, Maiden Surname) Pearl Transou							
19a. Informant's Name/Relationship (Type, Print) Beuna O. Conrad/wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 Bethel Road Finksburg, MD 21048							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sandymount Church Cem			Date 5/26/99		20c. Location - City or Town, State Sandymount, MD				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ATHEROSCLEROTIC CORONARY HEART DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RHEUMATIC HEART DISEASE												
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. Signature and title of certifier 			29c. License number DO 1663		29d. Date signed (Month, Day, Year) 5/24/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VINCENT J. FIOCCO JR					30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 906C WASHINGTON RD WESTMINSTER, MD 21157							
31. Date filed (Month, Day, Year) MAY 25 1999					32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18622

Amend #29a Per Phys. PGC 6-1-99 cr

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Anna Carter</i>				2. Date of Death Month <i>05</i> Day <i>25</i> Year <i>99</i>		3. Time of Death <i>0810A</i>	
	4a. Facility Name (If not institution, give street and number) <i>Prince Georges General Hospital</i>				4b. City, Town, or Location of Death <i>Cheverly</i>		4c. County of Death <i>Prince Georges</i>	
Funeral Director	5. Social Security Number <i>160-206157</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>74</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>June 14, 1924</i>	9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>
	Usual Residence of Decedent				10a. State <i>Maryland</i>		10b. County <i>Prince Georges</i>	
10c. City, Town or Location <i>Hyattsville</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <i>7746 Decatur Avenue</i>				10f. Zip Code <i>20784</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>		
17. Father's Name (First, Middle, Last) <i>Adam Bobak</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Anna Kapirta</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Howard R. canter/Husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7746 Decatur Road Hyattsville, Md. 20784</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lakemont Memorial Gardens</i>		Date <i>05-29-99</i>		20c. Location - City or Town, State <i>Davidsonville, Maryland</i>	
21. Signature of Funeral Service Licensee <i>Shannon W. Ramirez</i> <i>Shannon W. Ramirez M00798</i>				22. Name and Address of Facility <i>Beall Funeral Home</i> <i>6512 N.W. Crain Highway Bowie, Md. 20715</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>LETHAL ARRHYTHMIA</i> Due to (or as a consequence of): <i>CARDIAC CONDUCTION DISEASE</i> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28e. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i> MD				29c. License number <i>00046776</i>		29d. Date signed (Month, Day, Year) <i>5/25/99</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Tery Jodrie 3001 Hospital Drive Cheverly, Maryland 20785</i>								
31. Date filed (Month, Day, Year) <i>MAY 27 1999</i>				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature or initials

1935 & 1936

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18623

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY CRUMP				2. Date of Death Month 05 Day 23 Year 99		3. Time of Death 12:50 pm		
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 579-34-5463		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) June 29, 1925		
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State MD		10b. County Prince George's		10c. City, Town or Location Washington, D.C.		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 601 L Street, S.E., #412		10f. Zip Code 20003		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) House Keeper		16b. Kind of Business/Industry Private					
17. Father's Name (First, Middle, Last) Harry Morton				18. Mother's Name (First, Middle, Maiden Surname) Viola Brown					
19a. Informant's Name/Relationship (Type, Print) Shelia R. Clemons/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3901 Biscoe Court, Mitchellville, Maryland 20721					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		20c. Location - City or Town, State Brentwood, Maryland		20d. Date 05/28 1999			
21. Signature of Funeral Service Licensee Nancy A. Perentis				22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary artery disease Due to (or as a consequence of): b. Renal failure Due to (or as a consequence of): c. Sepsis Due to (or as a consequence of): d. 1DDM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier A. Rahimian MD							
		29c. License number D05299		29d. Date signed (Month, Day, Year) 05/23/99					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALI RAHIMIAN MD 1328 Southern Ave., Suite #202, Wash., D.C. 20032									
31. Date filed (Month, Day, Year) MAY 26 1999		32. Registrar's Signature B. Apali							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Division of Vital Records, P.O. Box 68760,

Joseph B. Smith, PRESIDENT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18624

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA PEARL CARPENTER

2. Date of Death

May 21 1999

3. Time of Death

05:05 PM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

238-56-1640

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 7-1937

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11809 OLD COLUMBIA PIKE

10f. Zip Code

20904

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

FRANK BURRWELL

18. Mother's Name (First, Middle, Maiden Surname)

LUCY MAYFIELD

19a. Informant's Name/Relationship (Type, Print)

WILLIAM CARPENTER / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11809 OLD COLUMBIA PIKE, SILVER SPRING, MD 20904

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEKE CREMATORY

Date

5-26-99

20c. Location - City or Town, State

BELTSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME

11315 LOCKWOOD DRIVE, SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MASSIVE INTRACEREBRAL HEMORRHAGE

Due to (or as a consequence of):

b. Anti Coagulated State

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 DAY

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY

Right Atrial Thrombus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30898

29d. Date signed (Month, Day, Year)

May 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven F. Osborne MD 1500 Forest Glen Rd Silver Spring MD 20910

31. Date filed (Month, Day, Year)

MAY 26 1999

32. Registrar's Signature

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

9881-1-1 YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18625

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AGNES ROSALIE COLLINS					2. Date of Death Month Day Year May 27, 1999		3. Time of Death 7:40AM			
	4a. Facility Name (If not institution, give street and number) 9140 Chapel Point Road					4b. City, Town, or Location of Death Bel Alton		4c. County of Death Charles			
Funeral Director	5. Social Security Number 220-32-7252		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) July 23, 1922		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD		10b. County Charles		10c. City, Town or Location Bel Alton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 9140 Chapel Point Road					10f. Zip Code 20611		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping			16b. Kind of Business/Industry Domestic			
17. Father's Name (First, Middle, Last) Mosses Ford					18. Mother's Name (First, Middle, Maiden Surname) Ruth Gross Ford						
19a. Informant's Name/Relationship (Type, Print) Frances Collins/Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 204 Bel Alton, MD 20611						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cemetery			20c. Location - City or Town, State La Plata, MD		20d. Date 6/1/99			
21. Signature of Funeral Service Licensee <i>David C. Echols</i> MO0945					22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA Plata, MD 20646						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Heart Disease Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>Yashia M. Tagoori</i> M.D.					29c. License number DB0883		29d. Date signed (Month, Day, Year) 5-28-99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YASHIA M. TAGOORI MD 11655 WINECAP PL La Plata MD 20646											
31. Date filed (Month, Day, Year) JUN 01 1999			32. Registrar's Signature <i>B. Sparks</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18626

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James W. Crosby, Jr.

2. Date of Death
Month Day Year
May 23, 19993. Time of Death
10:24 a.m.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director5. Social Security Number
216 24 48 796. Sex
☒ M ☐ F7. Age (In yrs. last birthday)
73 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
Jan 21, 19269. Birthplace (State or Foreign
Country)
Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Lothian

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1047 Lower Pindell Road

10f. Zip Code

20711

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1944-4613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

proprietor, manager

16b. Kind of Business/Industry

rental properties

17. Father's Name (First, Middle, Last)

James Wesley Crosby, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Virginia Catterton

19a. Informant's Name/Relationship (Type, Print)

Arvella B. Crosby/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as # 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Friendship Church Cem.

Date

5-27-99

20c. Location - City or Town, State

Friendship, MD

21. Signature of Funeral Service Licensee

William B. H.

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Tarrynople Ventricular Fibrillation

Due to (or as a consequence of):

b.

Myocardial Infarction

Due to (or as a consequence of):

c.

Coronary Arter Disease

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

4 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

Edward Riuli

29c. License number

D36549

29d. Date signed (Month, Day, Year)

5/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward Riuli, M.D., 180 Thomas Johnson Drive, Frederick, MD 21702

31. Date filed (Month, Day, Year)

MAY 26 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18627

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Milton Conner				2. Date of Death Month May Day 23 Year 1999				3. Time of Death 1:02 A.M.																	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's																	
Funeral Director	5. Social Security Number 577-07-3366		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) May 4, 1912		9. Birthplace (State or Foreign Country) Maryland																	
	Usual Residence of Decedent																									
10a. State Maryland		10b. County Charles		10c. City, Town or Location Waldorf				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
10e. Street and Number 70 Village Street #220				10f. Zip Code 20602				10g. Citizen of What Country? U.S.A.																		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lagicitic				16b. Kind of Business/Industry Andrews Air Force Base																		
17. Father's Name (First, Middle, Last) Vernon Conner				18. Mother's Name (First, Middle, Maiden Surname) Annabella Bothick																						
19a. Informant's Name/Relationship (Type, Print) Mary Bowersox (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9025 Basswood Run Bel Alton Maryland 20611																						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens				20c. Location - City or Town, State Davidsonville, MD																		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735																						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																										
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Septic Shock</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Coronary artery disease</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Diabetes Mellitus</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Prenal failure</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Septic Shock	Due to (or as a consequence of):		b.	Coronary artery disease	Due to (or as a consequence of):		c.	Diabetes Mellitus	Due to (or as a consequence of):		d.	Prenal failure	Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Septic Shock	Due to (or as a consequence of):																							
	b.	Coronary artery disease	Due to (or as a consequence of):																							
	c.	Diabetes Mellitus	Due to (or as a consequence of):																							
	d.	Prenal failure	Due to (or as a consequence of):																							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred																		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																										
29b. Signature and title of certifier 				29c. License number D0052999				29d. Date signed (Month, Day, Year) 05/23/99																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rahimian M.D. 1328 Southern Avenue #202 Washington DC 20032																										
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature 																						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

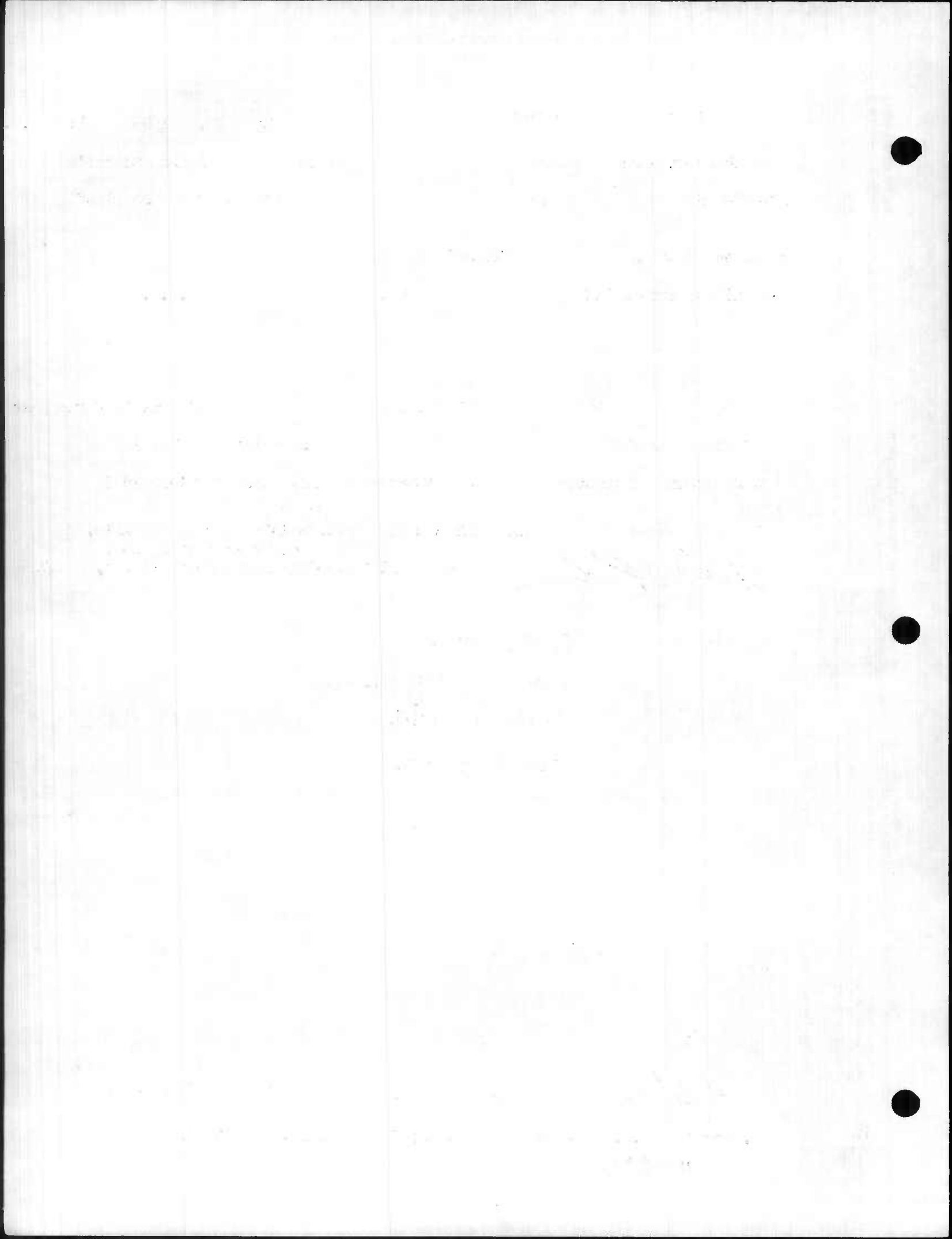
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18628

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALVA VIRGINIA CREIGHTON			2. Date of Death Month Day Year June 1 1999		3. Time of Death 00:40	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 215 18 4610	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov 30 1915	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Calvert	10c. City, Town or Location Broomes Island			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 3956 Oyster House Road			10f. Zip Code 20615		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seafood packing plant		16b. Kind of Business/Industry Seafood		
	17. Father's Name (First, Middle, Last) George Parks			18. Mother's Name (First, Middle, Maiden Surname) Annie Ashton			
	19a. Informant's Name/Relationship (Type, Print) Loretta Anderson- daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7576 Hogans Lane Salisbury MD 21801			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		20c. Location - City or Town, State Hurlock, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Myocardial Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						
	Approximate Interval Between Onset and Death unk unk						
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary atherosclerosis, atrial fibrillation					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
			28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and Title of certifier 		29c. License number D 27189		29d. Date signed (Month, Day, Year) 6/1/99		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zahir Yousaf, M.D. 2417 Solomons Island Rd. Huntingtown, Md 20639						
	31. Date filed (Month, Day, Year) JUN 02 1999		32. Registrar's Signature 				

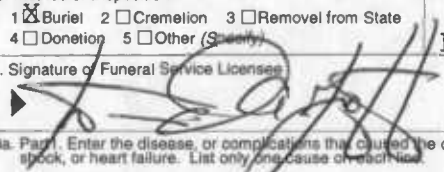
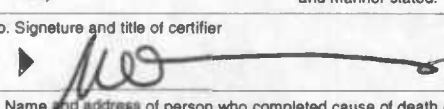
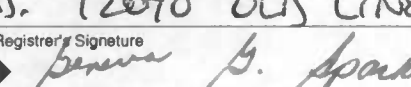
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18629

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCES T. CUTLIP				2. Date of Death Month Day Year MAY 28, 1999		3. Time of Death 4:25 P		
	4a. Facility Name (If not institution, give street and number) SOUTHEAST MARYLAND HOSPITAL				4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 578 24 3945		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year) March 2, 1915		9. Birthplace (State or Foreign Country) West Virginia		
	10e. State MD		10b. County Prince George's		10c. City, Town or Location Hyattsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Usual Residence of Decedent 10e. Street and Number 6511 Parkway Court				10f. Zip Code 20782		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+)			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress			16b. Kind of Business/Industry Resturant			
17. Father's Name (First, Middle, Last) William A. Manuel				18. Mother's Name (First, Middle, Maiden Surname) Margie F. Peacher					
19a. Informant's Name/Relationship (Type, Print) Edward Matthews (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 Brent Road, Waldorf, Maryland 20602					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery June 3, 1999 Brentwood, Maryland		20c. Location - City or Town, State			
21. Signature of Funeral Service Licenses 				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE GASTROINTESTINAL BLEEDING DAYS Due to (or as a consequence of): DIVERICULOSIS Due to (or as a consequence of): YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE CONGESTIVE HEART FAILURE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D-18545		29d. Date signed (Month, Day, Year) MAY 28, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. WISOTZKY M.D. 12070 OLD LINE CENTER WALDORF Md.									
31. Date filed (Month, Day, Year) JUN 01 1999				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

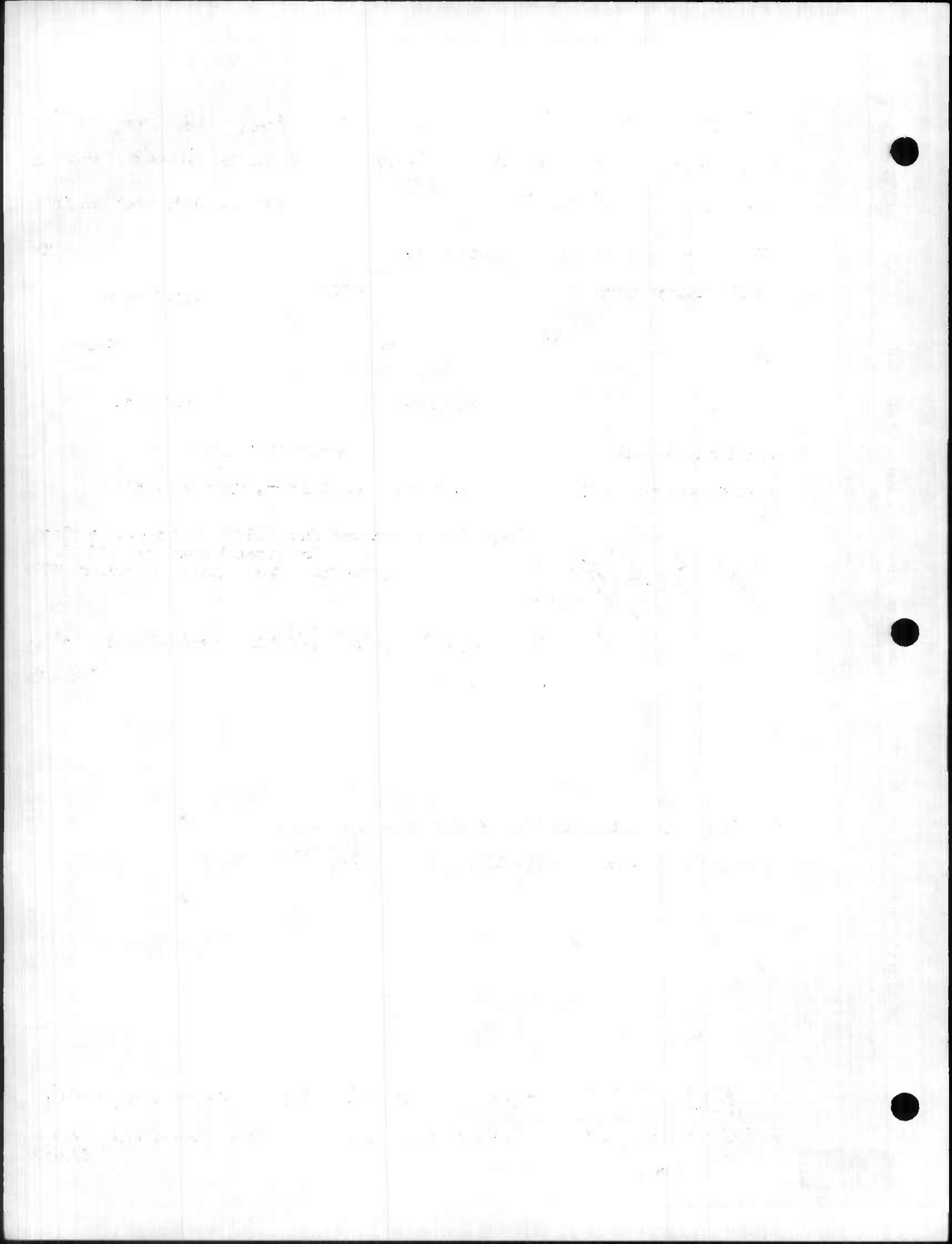
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

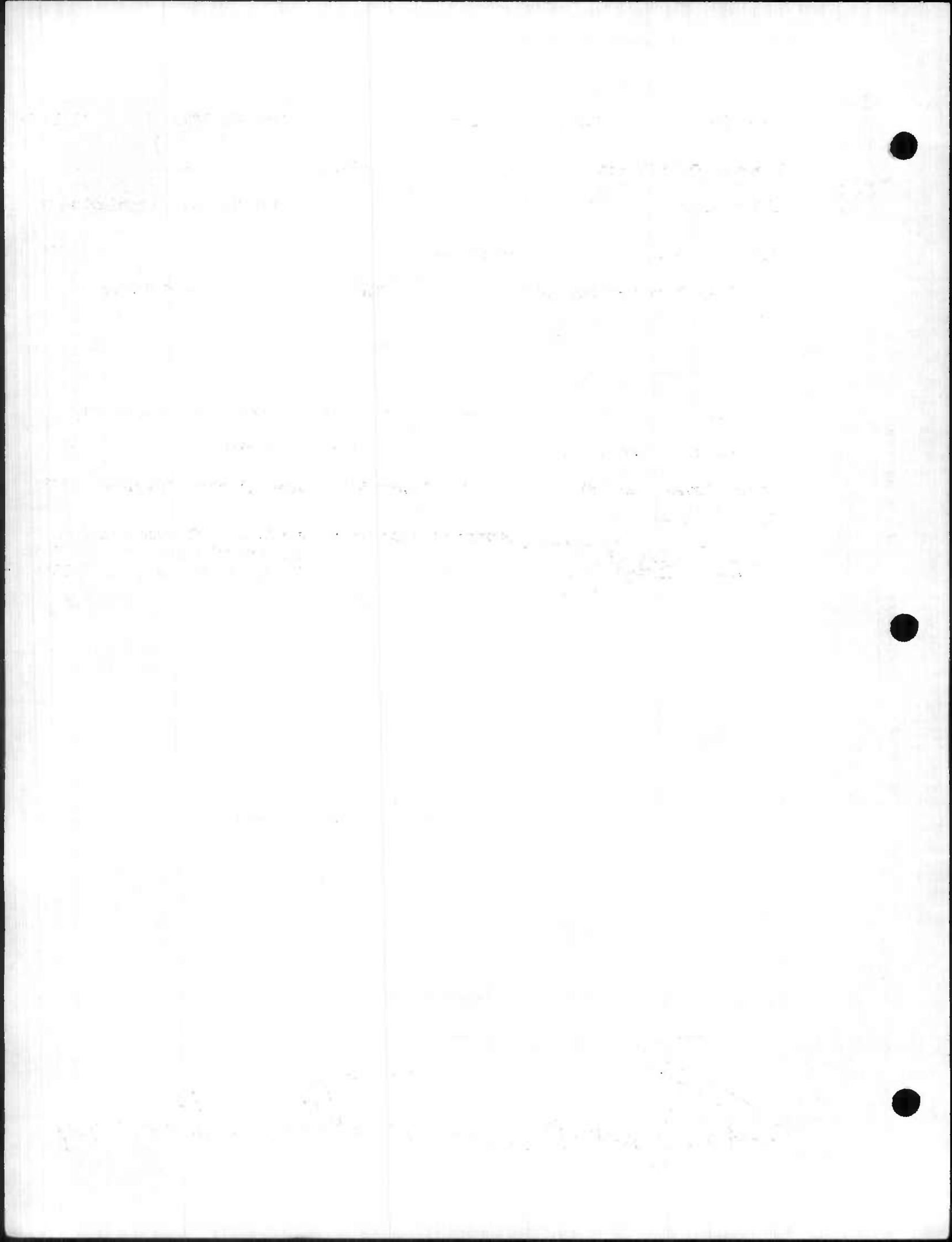
Reg. No.

99 18630

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cathleen Clare Carney				2. Date of Death May 27, 1999		3. Time of Death 11:10 AM	
	4e. Facility Name (If not institution, give street and number) Bradford Oaks Nursing Home				4b. City, Town, or Location of Death Clinton		4c. County of Death P.G.	
Funeral Director	5. Social Security Number 219 48 0220		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 46	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 31, 1952	9. Birthplace (State or Foreign Country) Washington DC
	Usual Residence of Decedent				10a. State MD		10b. County P.G.	
To Be Completed by Funeral Director	10c. City, Town or Location Indian Head				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5045 Masons Spring Road	
	10f. Zip Code 20640				10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dept of Navy - Contact Spec. U.S. Government		16b. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) Walter A. Carney, Jr.				18. Mother's Name (First, Middle, Maiden Surname) Rita V. Zmyslowski			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Diane Carney (SISTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7405 Clinton Vista Lane, Clinton, Maryland 20735			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery June 1, 1999 Clinton, Maryland		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Nasopharyngeal cancer w/ thrombosis / ym Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin dependent diabetes mellitus				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DQA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier		
29c. License number D19431				29d. Date signed (Month, Day, Year) 5/27/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin D. Ryan MD 11701 Livingston Rd #200 FT. WORTH MD 20744		
31. Date filed (Month, Day, Year) JUN 01 1999				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18631

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Julie Anne Cox					2. Date of Death Month Day Year MAY 25, 1999		3. Time of Death 5:09P.M.			
	4a. Facility Name (If not Institution, give street and number) 5992 HILLSIDE ROAD					4b. City, Town, or Location of Death ST. LEONARD		4c. County of Death CALVERT			
Funeral Director	5. Social Security Number 212 08 7744		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 14 Yrs.		8. Date of Birth (Month, Day, Year) October 31, 1984		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Calvert		10c. City, Town or Location Huntingtown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 85 M.F. Bowen Road				10f. Zip Code 20639		10g. Citizen of What Country? United States					
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) student			16b. Kind of Business/Industry n/a				
17. Father's Name (First, Middle, Last) James Leroy Cox, Jr.					18. Mother's Name (First, Middle, Maiden Surname) Nancy Susan Miner						
19a. Informant's Name/Relationship (Type, Print) James L. Cox, Jr. - father					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85 M.F. Bowen Rd. HUNTINGTOWN, MD 20639						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Central Cemetery			Date May 28, 1999		20c. Location - City or Town, State Barstow Maryland			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. rd. Port Republic MD 20676						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Compensated Arrhythmia and Head and Neck Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE								
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) End 5/25/99		28b. Time of injury 1700 HR		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject was struck by a falling object from a roof.		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) woodway							28f. Location (Street and Number or Rural Route Number, City or Town, State) 5992 Hillside Road St. Leonard Maryland	
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 					29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 26, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) MAY 27 1999			32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18632

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Fletcher Comegys

2. Date of Death

Month

Day

Year

May

7

1999

3. Time of Death

0810

4a. Facility Name (If not institution, give street and number)

The Kent and Queen Anne's Hospital, Inc.

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral
Director

5. Social Security Number

219-14-3990

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 3, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Queen Anne's

10c. City, Town or Location

Centreville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

141 Fairview Farm Lane

10f. Zip Code

21617

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

3

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Self employed Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Alfred Comegys

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Mandrell

19a. Informant's Name/Relationship (Type, Print) (Son)

Henry F. Comegys, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

214 Walnut St., Church Hill, Md. 21623

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesterfield Cemetery

Date

May 10, 1999

20c. Location - City or Town, State

Centreville, Md.

21. Signature of Funeral Service Licensee

Charles M. H. H. H.

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home
408 S. Liberty St., Centreville, Md.23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Congestive Heart Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 Days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Cor Pulmonale

Due to (or as a consequence of):

3 yrs

d. End Stage Chronic Bronchitis

20 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Left Ventricular Hypertrophy
Dilated Left Ventricle with EF of 20-30%
Severe Tricuspid Regurgitation; Dehydration

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George M. Young MD

29c. License number

D3 1979

29d. Date signed (Month, Day, Year)

May 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE M. YOUNG

100 BROWN ST
CHESTERTOWN MD 21620

31. Date filed (Month, Day, Year)

MAY 10 1999

32. Registrar's Signature

Benita G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text, mostly illegible due to fading. Some words like "The", "and", "of" are visible. There are some numbers and possibly dates.

Handwritten text, mostly illegible due to fading. Some words like "The", "and", "of" are visible. There are some numbers and possibly dates.

Handwritten text, mostly illegible due to fading. Some words like "The", "and", "of" are visible. There are some numbers and possibly dates.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18633

10 1/9
Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) HOWARD RANDOLPH DANDRIDGE				2. Date of Death Month Day Year MAY 19, 1999		3. Time of Death 7:19 pm	
4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
5. Social Security Number 579-66-0418		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 4, 1951	
9. Birthplace (State or Foreign Country) WASHINGTON DC							
Usual Residence of Decedent							
10a. State MD		10b. County PRINCE GEORGES		10c. City, Town or Location SUITLAND, MD		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2108 SPAULDING AVE				10f. Zip Code 20746		10g. Citizen of What Country? UNITED STATES	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MASONARY		16b. Kind of Business/Industry FED GOVT	
17. Father's Name (First, Middle, Last) ALVIN DANDRIDGE				18. Mother's Name (First, Middle, Maiden Surname) MARY GLADYS TAYLOR			
19a. Informant's Name/Relationship (Type, Print) EVELYN M. GRAY / SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 QUE ST S.E. WASHINGTON DC 20020			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK		20c. Date 5-27-99		20d. Location - City or Town, State LANDOVER, MD	
21. Signature of Funeral Service Licensee Alex A Pope				22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES 2617 PENN. AVE S.E. WASHINGTON DC 20020			

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Multicentric Hepatoma</u> Due to (or as a consequence of): b. <u>Hepatitis C</u> Due to (or as a consequence of): c. <u>Alcoholism</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 year 6 years 6 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Angela L Corbin MD		29c. License number D35421		29d. Date signed (Month, Day, Year) MAY 20 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANGELA L. CORBIN MD 1500 Forest Glen Rd Silver Spring MD 20910					
31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature B. Sparks			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18634

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD L. DEPUTY				2. Date of Death Month May Day 25 Year 1999		3. Time of Death 7:15PM	
	4a. Facility Name (If not institution, give street and number) VA MARYLAND HEALTH CARE SYSTEM				4b. City, Town, or Location of Death PERRY POINT		4c. County of Death CECIL	
Funeral Director	5. Social Security Number 214-07-5706		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 8, 1911	9. Birthplace (State or Foreign Country) West Virginia
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Cecil		10c. City, Town or Location North East			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 102 River Manor Drive				10f. Zip Code 21901		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: US Army 1941-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Tool & Die	
	17. Father's Name (First, Middle, Last) Guy Deputy				18. Mother's Name (First, Middle, Maiden Surname) Edna Liller			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Erma Deputy / Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 River Manor Drive, North East, MD 21901			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cem.		Date May 29 1999		20c. Location - City or Town, State North East, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901			
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death Minutes Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARKINSON'S DISEASE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D42800		29d. Date signed (Month, Day, Year) May 25, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS BIONDO, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902								
31. Date filed (Month, Day, Year) MAY 28 1999		32. Registrar's Signature 						

NAME KNOWN TO PHYSICIAN: DEPUTY, RICHARD L.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

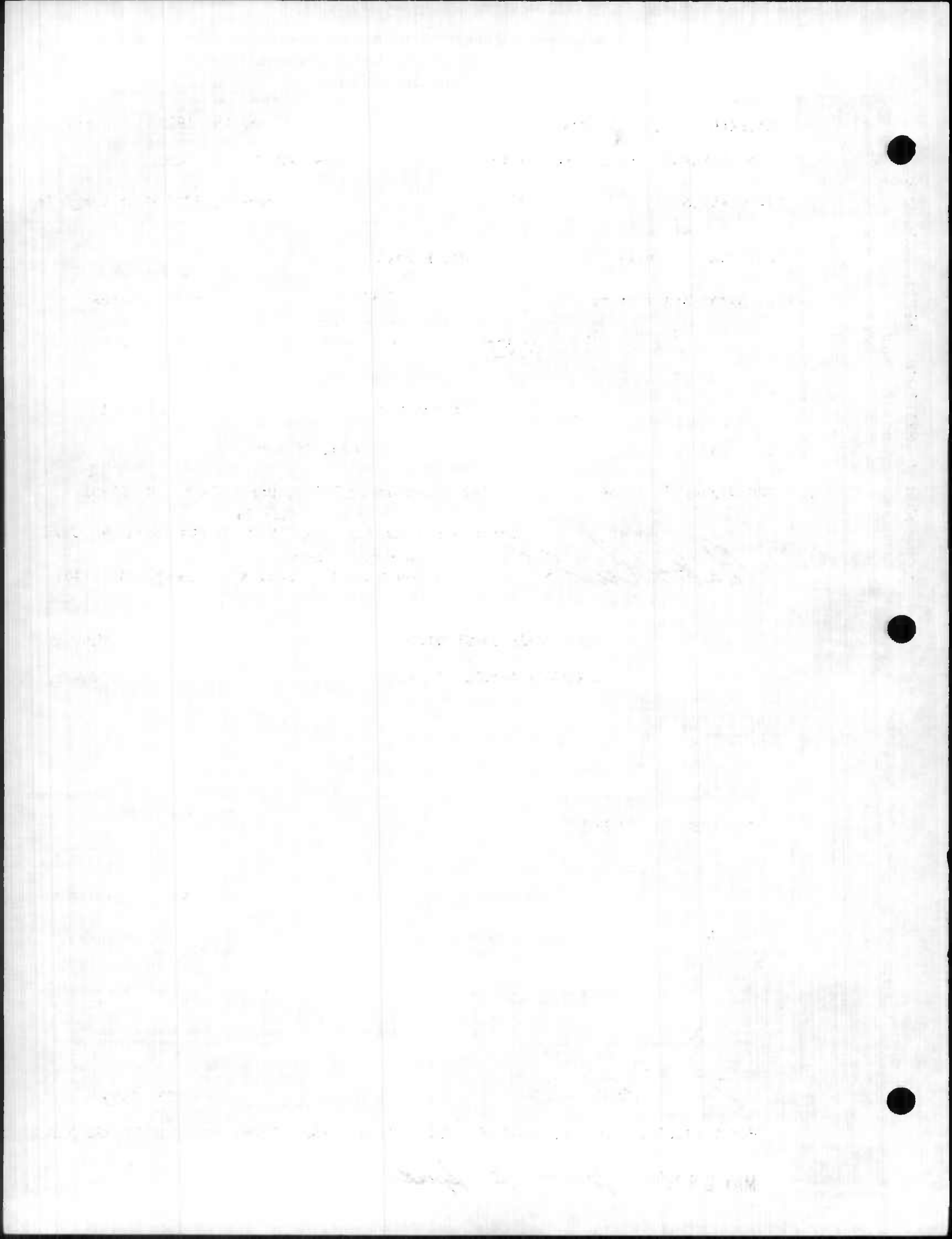
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8+1/4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18635

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT AUGUSTUS DAVIS				2. Date of Death Month Day Year MAY 25 1999		3. Time of Death 0803		
	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL				4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 196-22-0335		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) March 18, 1932		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Glenarden		
Usual Residence of Decedent									
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
10e. Street and Number 3100 Church Street				10f. Zip Code 20706		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1955 to 1961		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Specialist			16b. Kind of Business/Industry Government			
17. Father's Name (First, Middle, Last) Robert Augustus Davis, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Maeford					
19a. Informant's Name/Relationship (Type, Print) Genevieve V. Davis/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3100 Church Street, Glenarden, Maryland 20706					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		Date 06/03 1999		20c. Location - City or Town, State Cheltenham, Maryland		
21. Signature of Funeral Service Licensee <i>Behnag Jenkins</i>				22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785					
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>Mario F. Golie Jr. MD</i>			29c. License number D 33254		29d. Date signed (Month, Day, Year) MAY 25, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785									
31. Date filed (Month, Day, Year) MAY 27 1999			32. Registrar's Signature <i>B. Spate</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

State Registrar

MAY 2 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18636

Amend # 5. Per FH PGC 5-27-99 cr

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PICCOLA

DUKES

2. Date of Death
Month

Day

Year

3. Time of Death

5 24 1999 5:15 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE NURSING CENTER

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

578-32-1033

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 31, 1915

9. Birthplace (State or Foreign Country)

CHRISTIANSBURG, VA.

Usual Residence of Decedent

10a. State

D. C.

10b. County

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3813 MASS. AVE., S. E.

10f. Zip Code

20019

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 + YRS.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

D. C. PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

JAMES HOUSTON ALEXANDER

18. Mother's Name (First, Middle, Maiden Surname)

LUCY PICCOLA JORDAN

19a. Informant's Name/Relationship (Type, Print)

MARY WATERS-HEBRON--NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

804 STONESTREET AVENUE ROCKVILLE, MD 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

LINCOLN MEMORIAL CEMETERY 6/2/99 SUITLAND, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Theodore C. Pinckney

22. Name and Address of Facility

PINCKNEY-SPANGLER FUNERAL HOME

524 - 8TH ST., N. E. WASH., D. C. 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Adenocarcinoma Abdominal - Metastatic

Approximate Interval Between Onset and Death

3 Wks.

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Subdural Hematoma

Myocardial Infarction

Depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D28656

29d. Date signed (Month, Day, Year)

MAY 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYI KASSI MD. 8609 SECOND AVE, #404 B, S. SPRING, MD 20910

31. Date filed (Month, Day, Year)

MAY 27 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2291 • J. Neurosci., September 24, 2008 • 28(39):8283–8291

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18637

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Lillian Belle Davis				2. Date of Death Month May Day 25 Year 1999		3. Time of Death 1:50p.m.	
4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 271-12-6160		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 21, 1909	
9. Birthplace (State or Foreign Country) Virginia							
Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3386 Chiswick Court, Apt. 50-2B				10f. Zip Code 20906-1649		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4+ College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Medical	
17. Father's Name (First, Middle, Last) Harry Frederick Zahn, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Sarah Virginia Starner			
19a. Informant's Name/Relationship (Type, Print) Jeffery C. Richards, Attorney				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 75 Washington Street, Poughkeepsie, New York 12603			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunny Slope Cemetery		Date 5/28/1999		20c. Location - City or Town, State West Point, Virginia	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue Hyattsville, Maryland, 20781			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): b. Diverticulitis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 					
		29c. License number D50678		29d. Date signed (Month, Day, Year) 5/25/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajeez Batra, 10801 Lockwood Drive, Silver Spring, Maryland 20901							
31. Date filed (Month, Day, Year) MAY 28 1999		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

2201 8 S YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18638

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elma Irene Drake				2. Date of Death Month Day Year May 21, 1999				3. Time of Death 1:49 am	
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 215-38-6746		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 29, 1909		9. Birthplace (State or Foreign Country) Iowa	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Riverdale				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 4711 Queensbury Road				10f. Zip Code 20737				10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) (Unavailable) Kelderhouse				18. Mother's Name (First, Middle, Maiden Surname) (Unavailable)						
19a. Informant's Name/Relationship (Type, Print) Eldon D. Drake - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2400 Ridgeview Drive, Chino Hills, CA 91709						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Date 05/24/99		20d. Location - City or Town, State Brentwood, Maryland				
21. Signature of Funeral Service Licensee <i>Henry L. Ford</i>				22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. <i>paroxysmal Ventricular tachycardia</i> Due to (or as a consequence of): f. <i>ischemic heart disease</i> Due to (or as a consequence of): g. <i>Coronary atherosclerosis</i> Due to (or as a consequence of): h. Approximate Interval Between Onset and Death <i>hrs</i> <i>hrs</i> <i>hrs</i>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Septic shock, bowel gangrene, incarcerated right inguinal hernia, azotemia, hypertension, Anemia</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dr. Gustagi MD</i>		29c. License number D24720		29d. Date signed (Month, Day, Year) 5-21-99				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RAVINDER K. RUSTAGI MD 6132 LANDOVER ROAD, CHEVERLY, MD 20785										
31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature <i>Frank B. Spaid</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

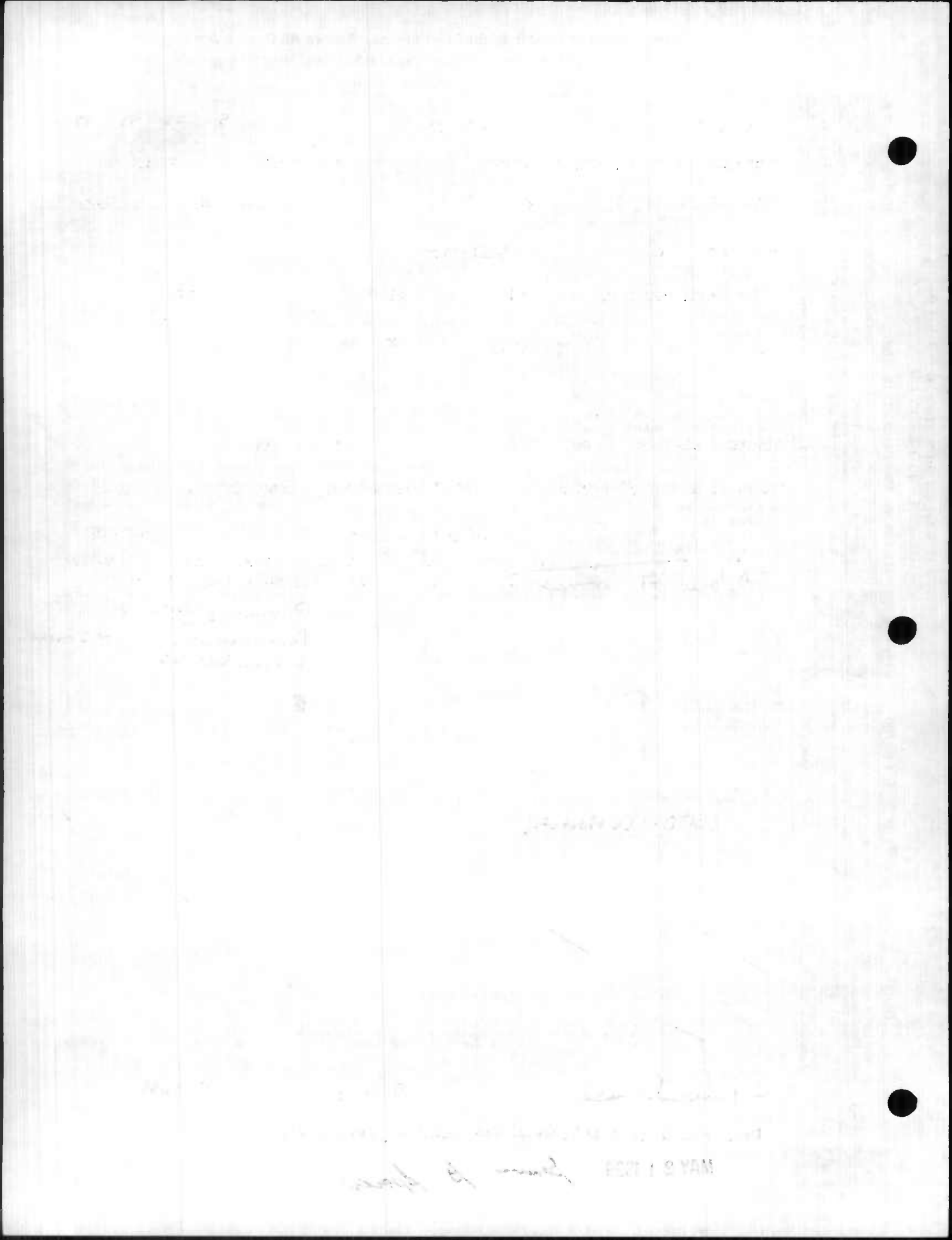
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18639

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM WADE DREYER SR				2. Date of Death Month 5 Day 23 Year 99		3. Time of Death 2320	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 304-12-5155		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) March 1, 1915	
	9. Birthplace (State or Foreign Country) Indiana		10e. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street end Number 227 Canal Park Dr., Apt. 301		10f. Zip Code 21804		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plant Manager		16b. Kind of Business/Industry Campbell Soup Co.			
	17. Father's Name (First, Middle, Last) Albert Frederick Dreyer				18. Mother's Name (First, Middle, Maiden Surname) Minnie Schleicher			
	19a. Informant's Name/Relationship (Type, Print) Sarah J. McGrath/Daughter				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 16048 Emerald Rd., Stony Creek, VA 23882			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 5/24/99		20c. Location - City or Town, State Salisbury, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804		23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory failure due to Amyotrophic Lateral Sclerosis		Approximate Interval Between Onset and Death ~ 3 months	
	23a. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD; no prostate,		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street end Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier 		29c. License number D26612		29d. Date signed (Month, Day, Year) 5-23-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Crouch, 105 Pine Bluff Rd, Salisbury, MD 21801		31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature 				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18640

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Marie Elizabeth Dashiell				2. Date of Death Month Day Year May 22, 1999		3. Time of Death 3:20 AM	
	4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare				4b. City, Town, or Location of Death Salisbury, MD		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 213-24-1360		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) June 4 1904	
	9. Birthplace (State or Foreign Country) Maryland		10a. State PA		10b. County Philadelphia		10c. City, Town or Location Philadelphia	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry None		17. Father's Name (First, Middle, Last) James Conway		
18. Mother's Name (First, Middle, Maiden Surname) Jennie Leonard		19a. Informant's Name/Relationship (Type, Print) Floyd Dashiell (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 North 55th Street Phila, PA 19139		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Green Acres		20c. Location - City or Town, State Salisbury, Md.		21. Signature of Funeral Service Licensee Gladys B. Stewart		22. Name and Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Chronic renal failure Due to (or as a consequence of): c. dementia Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death yes yes yes		Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier [Signature]		29c. License number 729349		29d. Date signed (Month, Day, Year) 5/24/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins, M.D. 1104 Healthway Dr. Salisbury MD 21804		
31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature [Signature]		State Registrar		6		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

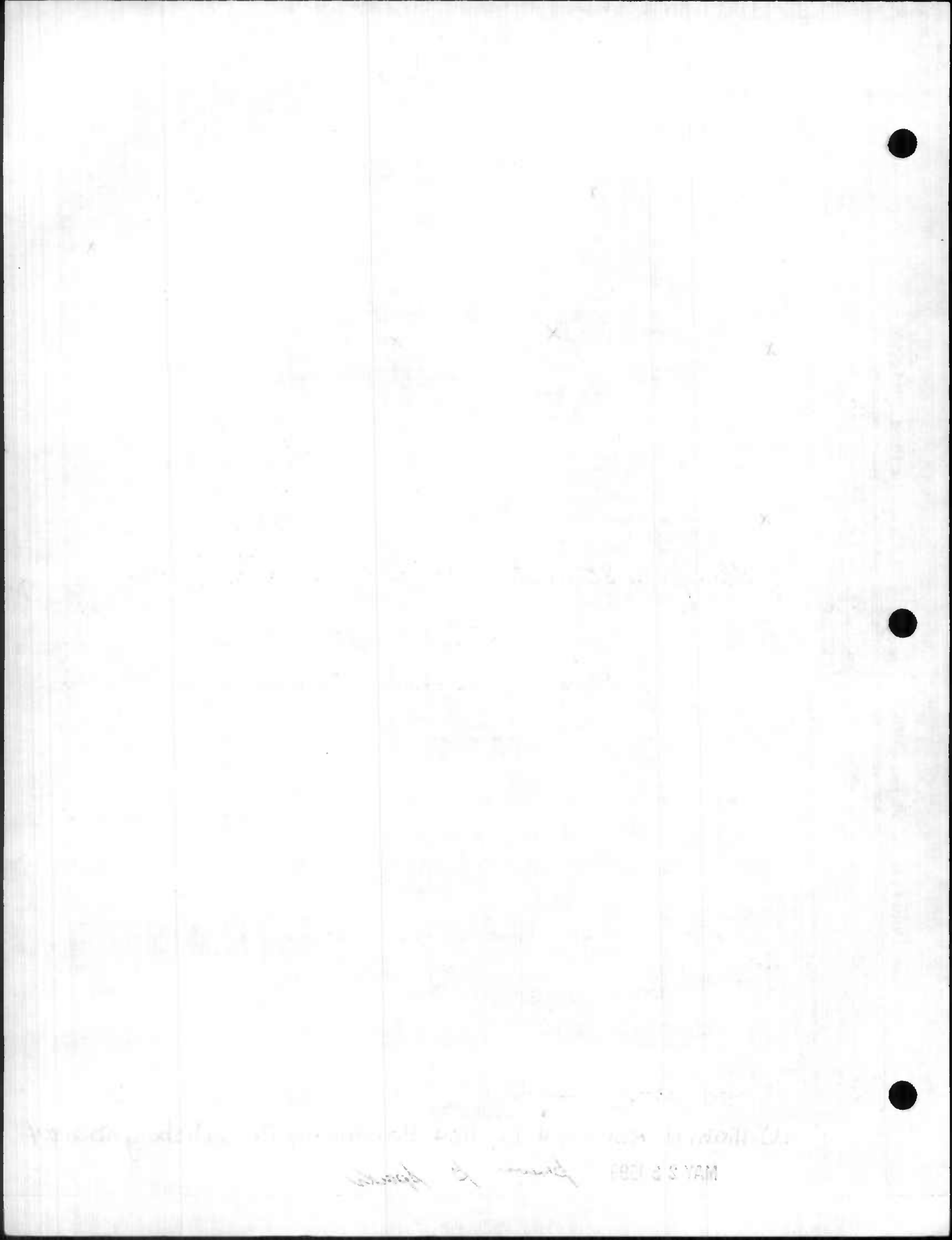
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

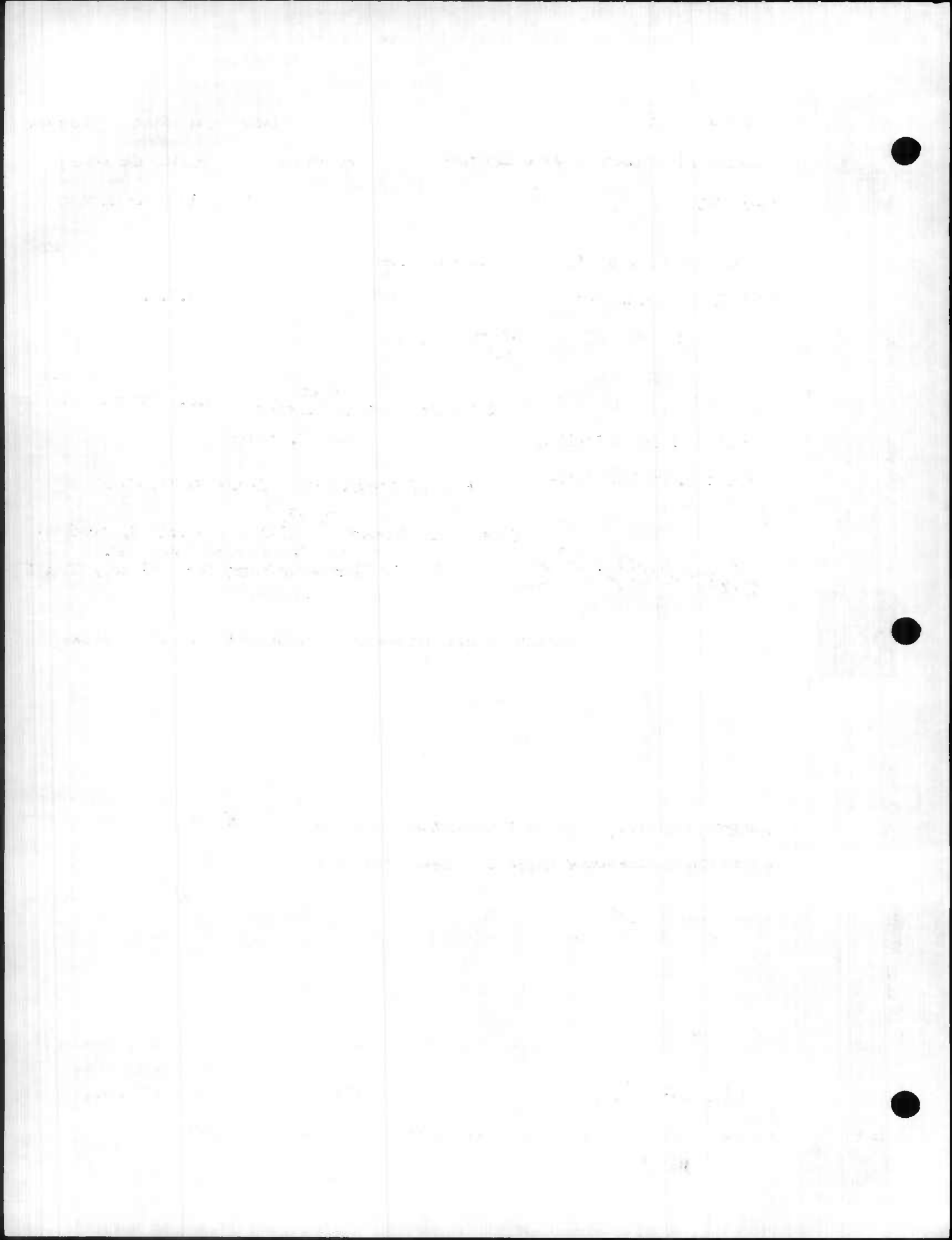
Reg. No.

99 18641

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROWLAND E. DARLING				2. Date of Death Month MAY Day 24 Year 1999		3. Time of Death 5:08 AM	
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL CENTER				4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGE'S	
Funeral Director	5. Social Security Number 578-03-7392		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 1, 1920	9. Birthplace (State or Foreign Country) Washington DC
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Temple Hills		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 4600 Old Branch Avenue				10f. Zip Code 20748		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1955		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Deputy Superintendent of Documents		16b. Kind of Business/Industry Printing U.S. Government Office		
17. Father's Name (First, Middle, Last) Rowland Earnest Darling				18. Mother's Name (First, Middle, Maiden Surname) Anne C. Evans				
19a. Informant's Name/Relationship (Type, Print) Frances A. Darling (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4600 Old Branch Avenue Temple Hills, MD 20748				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date May 27, 1999		20c. Location - City or Town, State Suitland, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735				
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION WITH CARDIOGENIC SHOCK Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 4 Days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES/MELLITUS, ATRIAL FIBRILLATION, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, RENAL FAILURE						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D38125		29d. Date signed (Month, Day, Year) MAY 25, 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) VINCENT CHEN, MD 9131 PISCATAWAY RD #600 CLINTON, MD 20735								
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18642

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernice Jarvis Edwards				2. Date of Death Month Day Year May 25, 1999		3. Time of Death 4:00 pm	
	4a. Facility Name (If not institution, give street and number) 3207 Tremont Avenue				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 245-34-3309		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 22, 1929	9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Cheverly			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 3207 Tremont Avenue				10f. Zip Code 20785		10g. Citizen of What Country? U.S. A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Kelly Jarvis				18. Mother's Name (First, Middle, Maiden Surname) Audie Hensley				
19a. Informant's Name/Relationship (Type, Print) Carroll D. Edwards - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3207 Tremont Avenue, Cheverly, Maryland 20785				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Sparta Cemetery		20c. Location - City or Town, State Sparta, NC		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781				
23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cirrhosis Due to (or as a consequence of): b. Alcohol abuse Due to (or as a consequence of): c. Renal insufficiency Due to (or as a consequence of): d. Edema						Approximate Interval Between Onset and Death 2 yrs ? 5 yrs 2 yrs 1 yr		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypothyroidism Dementia coagulopathy						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Ellen Yang M.D.		29c. License number D52170		29d. Date signed (Month, Day, Year) May 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellen Yang, M.D., 900 Bestgate Road, Suite 300, Annapolis, Maryland 21401								
31. Date filed (Month, Day, Year) MAY 28 1999				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

36

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18643

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HARRY W. FLEISHMAN, JR.				2. Date of Death Month Day Year MAY 25, 1999		3. Time of Death 10AM		
	4a. Facility Name (If not institution, give street and number) 322 CHARRED OAK COURT				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 719-03-1810		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (in yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 15, 1916	9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location ANNAPOLIS			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 322 CHARRED OAK COURT				10f. Zip Code 21401		10g. Citizen of What Country? UNITED STATES		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Crane Operator		16b. Kind of Business/Industry Construction				
	17. Father's Name (First, Middle, Last) Harry W. Fleishman, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Nellie Burbage				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sara M. Fleishman/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 322 Charred Oak Court Annapolis, MD 21401				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Epiphany Epis. Ch. Cem.		Date 5-28-99		20c. Location - City or Town, State Forestville, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Conjunctive Heart Failure</u> Due to (or as a consequence of): b. <u>Aortic STENOSIS</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D33069		29d. Date signed (Month, Day, Year) 5/26/99	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RICHARD BERNSTEIN 122 Defense Highway # 100 Annapolis 21401									
31. Date filed (Month, Day, Year) MAY 27 1999		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

18644

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

Elizabeth Edith Fox

2. Date of Death

May 23, 1999

3. Time of Death

4:30 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Hospice House of Hospice of the Chesapeake

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

5. Social Security Number

128-05-2862

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 4, 1915

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

41 McKinsey Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Harold Strathearn

18. Mother's Name (First, Middle, Maiden Surname)

Alice Stacey

19a. Informant's Name/Relationship (Type, Print)

Dr. Harold E. Fox / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 142, Gibson Island, MD 21056

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fairville Cemetery

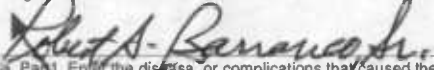
Date

May 26
1999

20c. Location - City or Town, State

Fairville, NY

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy., Severna Park, MD 2114623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. congestive heart failure

Approximate
Interval Between
Onset and Death

months

Due to (or as a consequence of):

b. ischemic cardiomyopathy

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

atrial fibrillation, mitral
regurgitation, dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D41955

29d. Date signed (Month, Day, Year)

5-24-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert E. Fox MD 1454 B & A Blvd Arnold MD 21012

State
Registrar

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

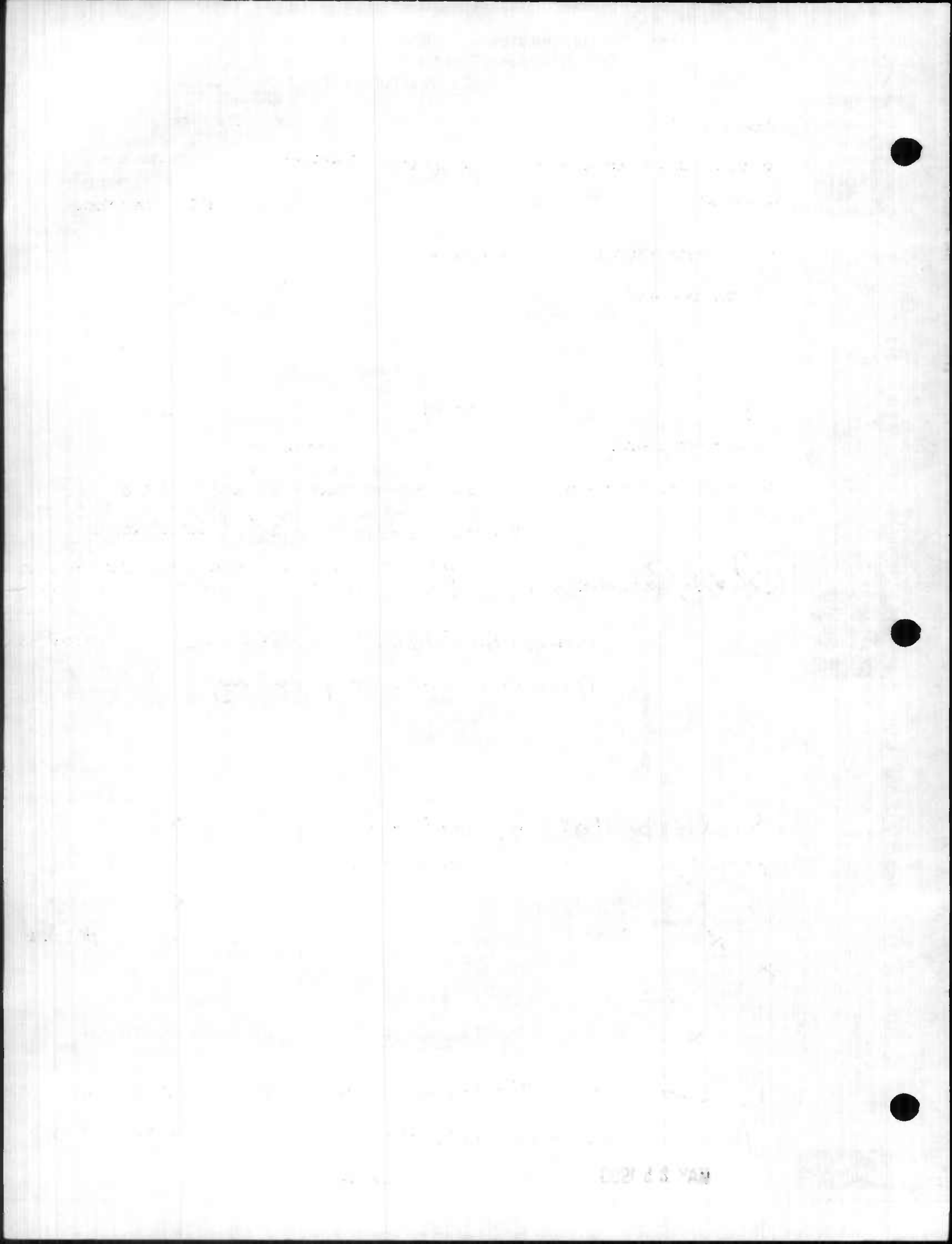
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23c or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18645

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Louise Ford				2. Date of Death Month Day Year May 25, 1999		3. Time of Death 4:10 AM	
	4a. Facility Name (If not institution, give street and number) Bayside Care Center				4b. City, Town, or Location of Death Lexington Park		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 214-68-9035		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 25, 1960	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County St. Marys		10c. City, Town or Location Lexington Park	
Usual Residence of Decedent								
10a. State Md.			10b. County St. Marys			10c. City, Town or Location Lexington Park		
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 214 71 Ritz Dr.			10f. Zip Code 20653		
10g. Citizen of What Country? U.S.A.			11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 10		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook			16b. Kind of Business/Industry Private Industry			17. Father's Name (First, Middle, Last) Unknown		
18. Mother's Name (First, Middle, Maiden Surname) Mary Jeter			19a. Informant's Name/Relationship (Type, Print) Dennis Ford			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 71 Ritz Dr., Lexington Park, Md., 20653		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Northern Virginia Crem. 5/26/99			20c. Location - City or Town, State Arlington, Va.		
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility Frazier's Funeral Home, Inc. 389 Rhode Island Av., NW, Washington, D.C., 20001					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Myocardial Infarction</i> Due to (or as a consequence of): b. <i>Coronary Artery Disease</i> Due to (or as a consequence of): c. <i>Arteriosclerosis</i> Due to (or as a consequence of): d. <i>Hypertension</i> Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>			29c. License number D34198			29d. Date signed (Month, Day, Year) 5/25/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David M. Rederick MD 24035 Three Notch Road 17015 Woodstock MD 20636</i>								
31. Date filed (Month, Day, Year) MAY 27 1999			32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

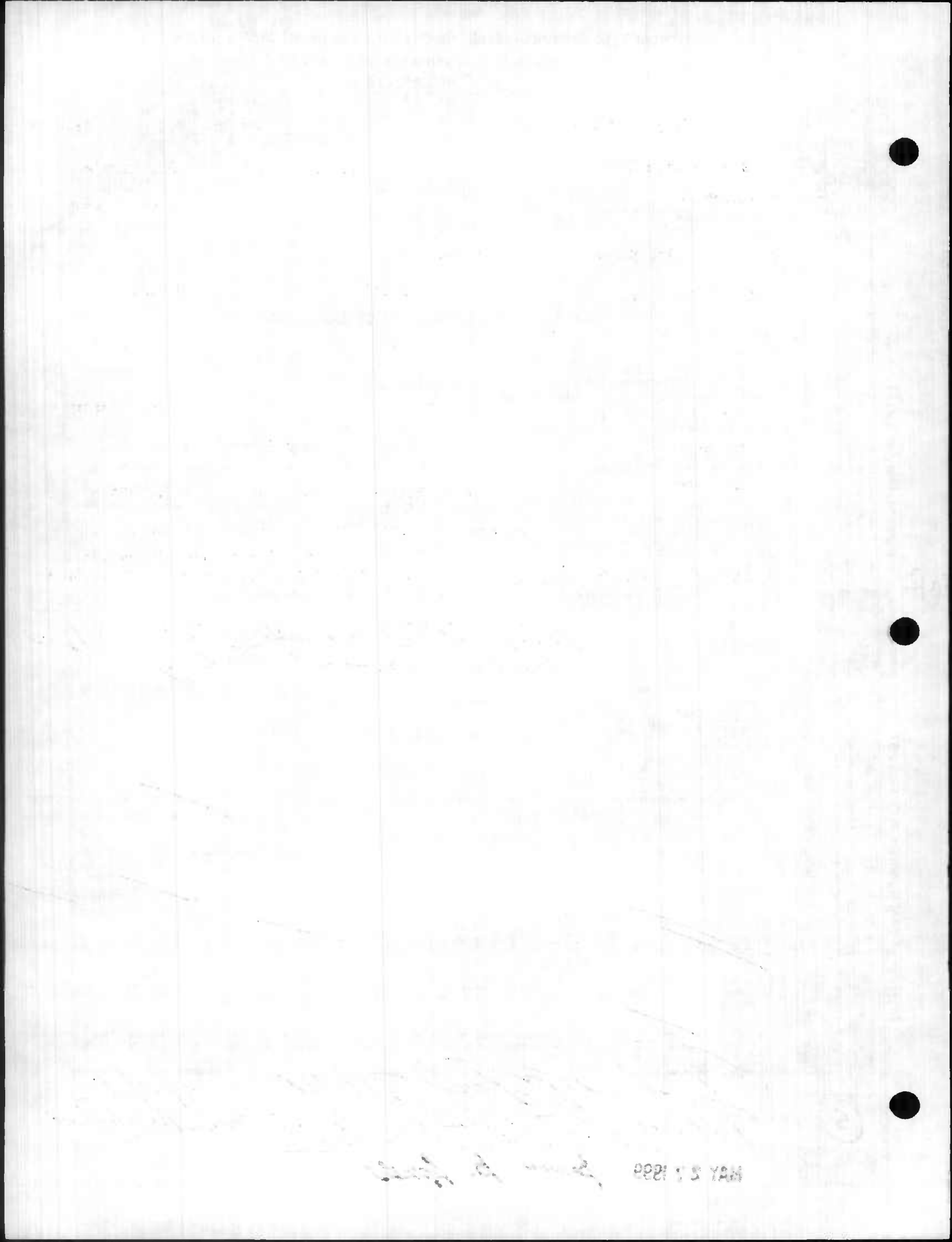
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



WAL 3 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Marie Flynn

2. Date of Death

Month
MayDay
26, 1999

3. Time of Death

11:10 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5708 Seminole Street

4b. City, Town, or Location of Death

Berwyn Heights

4c. County of Death

Prince George's

5. Social Security Number

579-42-8126

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 11, 1933

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Berwyn Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5708 Seminole Street

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Joseph Leo Dixon, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Catherine M. Beall

19a. Informant's Name/Relationship (Type, Print)

James J. Flynn - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5708 Seminole Street, Berwyn Heights, MD 20740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veteran's Cemetery

Date

06/03/99

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gasch's Funeral Home

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic esophageal cancer years.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D43575

29d. Date signed (Month, Day, Year)

May 27, 1999

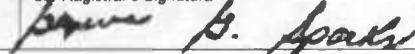
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angela Duncan, M.D. 7350 Van Dusen Road, Suite 130, Laurel, Maryland 20707

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18647

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RENA ODEN FORBES				2. Date of Death Month Day Year MAY 24, 1999		3. Time of Death 3:15pm	
	4a. Facility Name (If not institution, give street and number) CRESCENT CITY NURSING HOME				4b. City, Town, or Location of Death RIVERDALE		4c. County of Death P.G. COUNTY	
Funeral Director	5. Social Security Number 217-30-3813		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 101 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 12, 1898	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MD		10b. County PRINCE GEORGES		10c. City, Town or Location LANHAM			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 7216 KIDMORE LANE				10f. Zip Code 20706		10g. Citizen of What Country? UNITED STATES		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC			16b. Kind of Business/Industry PRIVATE	
17. Father's Name (First, Middle, Last) MACK ODEN				18. Mother's Name (First, Middle, Maiden Surname) MAGGIE ODEN				
19a. Informant's Name/Relationship (Type, Print) JOHN THOMAS FORBES/ SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7216 KIDMORE LANE, LANHAM, MD 20706				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RESURRECTION CEMETERY		Date 5-28-99		20c. Location - City or Town, State CLINTON, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME 5538 MARLBORO PIKE, FORESTVILLE, MD 20747				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Acute Myocardial infarction Due to (or as a consequence of): b. Ischemic heart disease Due to (or as a consequence of): c. Coronary atherosclerosis Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death minutes hrs hrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure, anaemia Electrolyte imbalance.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 024720		29d. Date signed (Month, Day, Year) 5-25-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6132 Landover Road, Cheverly MD 20785		31. Date filed (Month, Day, Year) MAY 26 1999						
32. Registrar's Signature 								

2 0/2

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18648

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rayfield Foreman, Jr.

2. Date of Death

Month Day Year
May 21 1999

3. Time of Death

9:30 am

4a. Facility Name (If not institution, give street and number)

514 Flower Street

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

214-36-7295

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 11, 1938

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

514 Flower Street

10f. Zip Code

21811

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

custodian

16b. Kind of Business/Industry

National Park

17. Father's Name (First, Middle, Last)

Rayfield Foreman, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Purnell

19a. Informant's Name/Relationship (Type, Print)

Belinda Foreman Dixon/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1006 Arthur Ct., Apt. 575, Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Calvary UMC Cemetery

Date

5/26/99

20c. Location - City or Town, State

Berlin, MD 21811

21. Signature of Funeral Service Director

22. Name and Address of Facility

Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 2180123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ASCVD

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

FEW YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ALCOHOLISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dorothy C. Holzworth, M.D.

29c. License number

D06241

29d. Date signed (Month, Day, Year)

05-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorothy C. Holzworth, M.D. 203 Snow St. Snow Hill, Md. 21863

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

Dorothy C. Holzworth

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

[Handwritten signature or initials.]

POD: 2 3 YAM

9

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18649

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Thomas Lee Foskey				2. Date of Death Month May Day 19 Year 1999		3. Time of Death 11PM
	4a. Facility Name (If not institution, give street and number) Salisbury Center; Genesis ElderCare				4b. City, Town, or Location of Death Salisbury, Md.		4c. County of Death Wicomico
Funeral Director	5. Social Security Number 213-42-0728	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 3, 1943	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 800 Fillmore Street				10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roofer		16b. Kind of Business/Industry Roofing Company	
17. Father's Name (First, Middle, Last) Vincent Foskey				18. Mother's Name (First, Middle, Maiden Surname) Myrtle Mosley Foskey Richardson			
19a. Informant's Name/Relationship (Type, Print) Naddah Mae Gordy/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Fillmore Street Salisbury, MD 21804			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cambridge Crematory		Date 5-21-99		20c. Location - City or Town, State Cambridge, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Short Funeral Home 13 E. Grove St. Delmar, DE 19940			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Two years Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Alcoholism						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D39813		29d. Date signed (Month, Day, Year) 5/20/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Atkins 1104 Healthway Drive Salisbury, MD, 21804							
31. Date filed (Month, Day, Year) MAY 21 1999		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18650

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERTA FRIEND		2. Date of Death Month May Day 26 Year 99		3. Time of Death 6:35A
	4. Facility Name (If not institution, give street and number) CARRIDGE HILL NURSING HOME - BETHESDA		5b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 112-07-8330	6. Sex 1 M 2 F X	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Usual Residence of Decedent 10a. State DC 10b. County Washington DC 10c. City, Town or Location Washington DC		9. Birthplace (State or Foreign Country) Feb. 01 1910 NEW YORK		10d. Inside City Limits 1 Yes 2 No
To Be Completed by Funeral Director	10e. Street and Number 2555 Pa Ave N.W.		10f. Zip Code 20037		10g. Citizen of What Country? United States
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ret USDA
	16b. Kind of Business/Industry Nutrition Analyst		17. Father's Name (First, Middle, Last) Charles James Friend		18. Mother's Name (First, Middle, Maiden Surname) Adelaide Friend
	19a. Informant's Name/Relationship (Type, Print) Arthur E. Tarantino, Robert		19b. Mailing Address (Post Office Box, Apartment, Suite, or Room Number, City, or Town, State, Zip Code) 1815 Pennsylvania Ave. N.W. Suite 900 Red Bar Building, Washington DC 20006		
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory May 27, 1999		20c. Location - City or Town, State Clinton, Maryland
	21. Signature of Funeral Service Licensee Kelli R. Datter		22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Vascular Insufficiency Due to (or as a consequence of): b. Atherosclerosis Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
	24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus					
25. Was case referred to medical examiner? 1 Yes 2 No					
26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide					
28a. Date of Injury (Month, Day Year) None 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier John B. Umhan MD 29c. License number D11024 29d. Date signed (Month, Day, Year) 5/26/99					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John B. Umhan MD, 8805 Conn. Ave., Chevy Chase, MD. 20815					
31. Date filed (Month, Day, Year) JUN 01 1999 32. Registrar's Signature Beverly B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

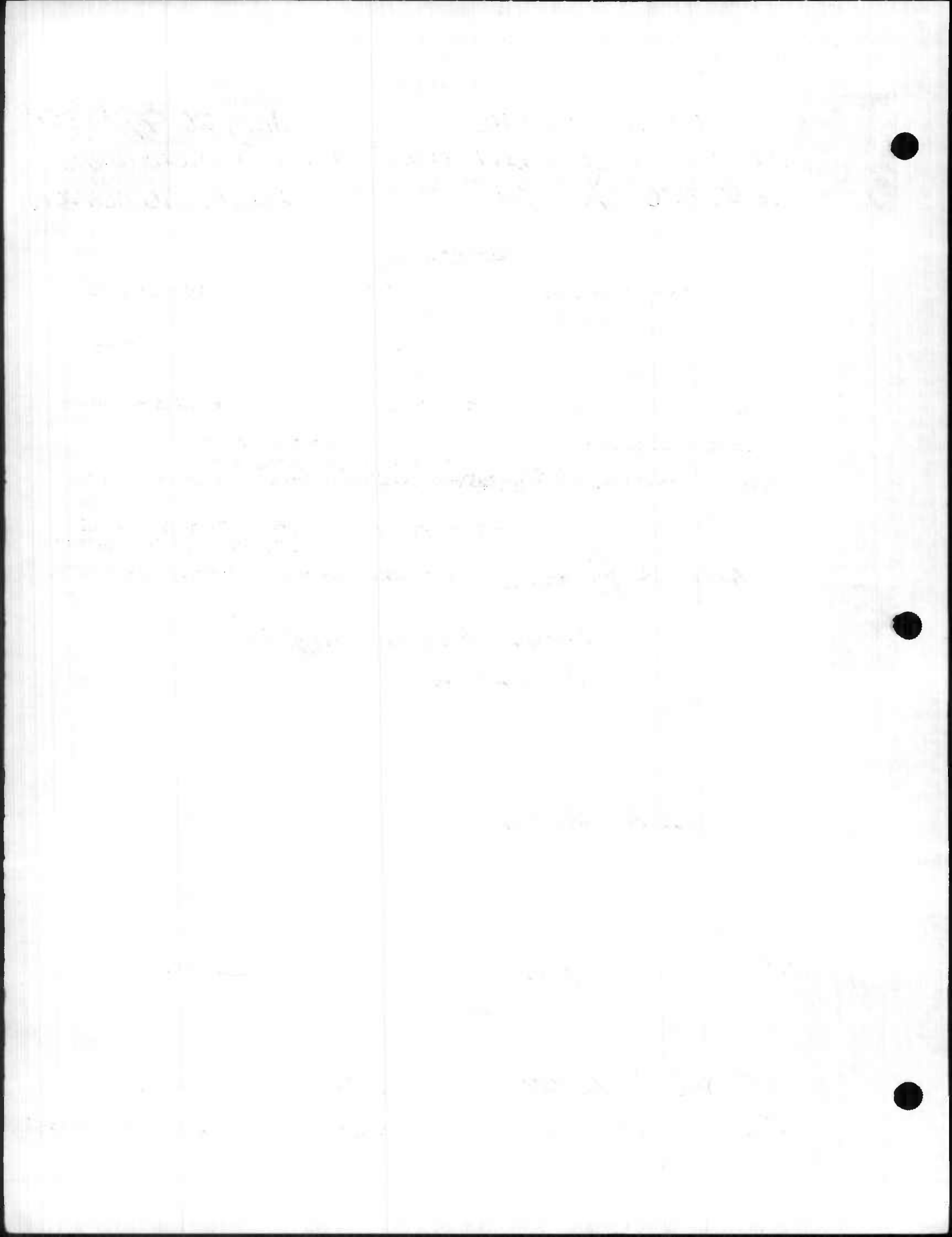
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18651

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GARY LEE GABBERT				2. Date of Death Month Day Year MAY 19, 1999				3. Time of Death 14:14		
	4e. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY				4c. County of Death PRINCE GEORGE'S		
Funeral Director	5. Social Security Number 218-40-1486		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) APR. 18, 1942		9. Birthplace (State or Foreign Country) WEST VIRGINIA		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10e. State MARYLAND		10b. County PRINCE GEORGE'S		10c. City, Town or Location BOWIE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 12007 TOWANDA LANE				10f. Zip Code 20715				10g. Citizen of What Country? UNITED STATES		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BARBER (SELF-EMPLOYED)				16b. Kind of Business/Industry COSMETOLOGY		
	17. Father's Name (First, Middle, Last) PAUL S. GABBERT				18. Mother's Name (First, Middle, Maiden Surname) EVA V. HOLBROOK						
	19a. Informant's Name/Relationship (Type, Print) DORIS GABBERT, WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12007 TOWANDA LANE, BOWIE, MARYLAND 20715						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CEMETERY		Date 5/24/99		20c. Location - City or Town, State BRENTWOOD, MARYLAND				
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Pneumonia Due to (or as a consequence of): f. Lung Carcinoma Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):								Approximate Interval Between Onset and Death weeks. year.		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery Disease								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i> M.D.				29c. License number D30318		29d. Date signed (Month, Day, Year) 5/19/99	
30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) JAMES CATAVENIS, M.D., 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785											
31. Date filed (Month, Day, Year) MAY 24 1999				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

10/10/1941

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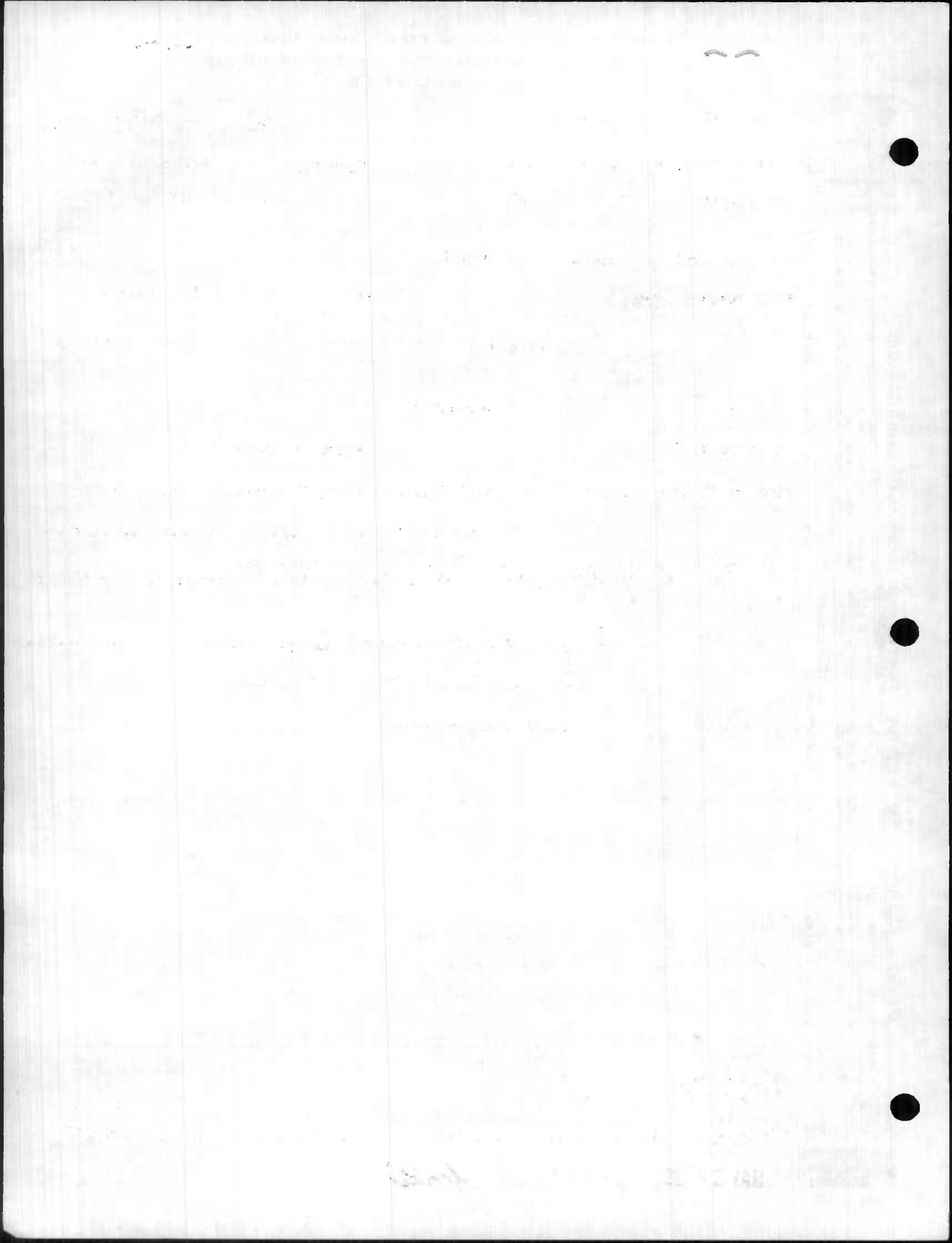
State of Maryland / Department of Health and Mental Hygiene

99 18652

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ru Fus Grubbs				2. Date of Death Month Day Year May 17 1999		3. Time of Death 0705hr	
	4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Center				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince Georges'	
Funeral Director	5. Social Security Number 238-14-5528		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 7, 1918	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Prince Georges'		10c. City, Town or Location Hyattsville	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 6703 Stockton Lane		10f. Zip Code 20784		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant		16b. Kind of Business/Industry Accounting			
	17. Father's Name (First, Middle, Last) Charles T. Grubbs				18. Mother's Name (First, Middle, Maiden Surname) Patricia Eloyse Louis			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Charles T. Grubbs, Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6703 Stockton Lane, Hyattsville, Maryland 20784			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Date 5/20/99		20d. Location - City or Town, State Brentwood, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Lisa S. Johnson				22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Due to (or as a consequence of): Diabetes Mellitus Due to (or as a consequence of): Arteriosclerosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes Mellitus Arteriosclerosis Acute Myocardial Infarction				Approximate Interval Between Onset and Death minutes			
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> PER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
State Registrar	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number 036979		29d. Date signed (Month, Day, Year) May 17, 1999	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah Sherrill 3001 Hospital Dr. Cheverly, MD 20785							
	31. Date filed (Month, Day, Year) MAY 24 1999				32. Registrar's Signature [Signature]			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 23a, Part I

State of Maryland / Department of Health and Mental Hygiene

99 18653

Per Phy., 5/25/99, Carroll County, wjl

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GENEVA WILLETTA GREEN				2. Date of Death Month MAY Day 22 Year 1999		3. Time of Death 5:33 PM	
	4a. Facility Name (If not institution, give street and number) 1714 STONE ROAD				4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 216-48-4455		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 8, 1915	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MD		10b. County CARROLL		10c. City, Town or Location WESTMINSTER			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1714 STONE ROAD				10f. Zip Code 21158		10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry DOMESTIC	
17. Father's Name (First, Middle, Last) DELBERT EARL GREEN				18. Mother's Name (First, Middle, Maiden Surname) MARY ETTA PARRISH				
19e. Informant's Name/Relationship (Type, Print) IDA BOWMAN/SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 STONE ROAD, WESTMINSTER MD 21158				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MT. PLEASANT CEM.		Date 5/26/99		20c. Location - City or Town, State GAMBER, MD
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 91 WILLIS STREET MYERS FUNERAL HOME WESTMINSTER, MD 21157				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiorespiratory failure Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last dementia								Approximate Interval Between Onset and Death 9 hrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29c. License number D33599			29d. Date signed (Month, Day, Year) 24 May 1999			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Philip J Ruzbarsky M.D. 128 Airport Drive Ste 34 Westminister, MD 21157								
31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

[Faint, illegible text covering the page, possibly bleed-through from the reverse side. The text is too light to transcribe accurately.]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) CHRISTINE RENEE GULDAN		2. Date of Death Month Day Year JUNE 3, 1999		3. Time of Death 0950 AM	
4a. Facility Name (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL			4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL
5. Social Security Number 217-86-2950	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 37 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 12, 1962
9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent					
10a. State MD	10b. County Howard	10c. City, Town or Location Woodbine		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 15620 Camden Meadows Court			10f. Zip Code 21797		10g. Citizen of What Country? U.S.A.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Assistant		16b. Kind of Business/Industry Computer	
17. Father's Name (First, Middle, Last) Norman Bruce Guldán			18. Mother's Name (First, Middle, Maiden Surname) Patricia Ann Pearson		
19a. Informant's Name/Relationship (Type, Print) Miss Melanie L. Duncan (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6505 Vert Drive Elkridge, MD 21075		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Serv.		20c. Location - City or Town, State 6/7/99 Hampstead, MD	
21. Signature of Funeral Service Licensee Brian L. Haight		22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (box 195) Sykesville, MD 21784 (410)-795-1400			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. MULTIPLE DRUG INTOXICATION Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found: 6-3-99		28b. Time of Injury A M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: RESIDENCE		28f. Location (Street and Number or Rural Route Number, City or Town, State) 15620 CAMDEN MEADOWS CT. WOODBINE, MD	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Wayne A. Yell		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 4, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne A. Yell 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUN 07 1999		32. Registrar's Signature B. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18655

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hilda Florene Glisan				2. Date of Death Month Day Year May 22 1999				3. Time of Death 6:00PM	
	4a. Facility Name (If not institution, give street and number) College View Center				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 213-42-1277		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 16, 1902		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10c. City, Town or Location Mt. Airy		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. State Maryland		10b. County Frederick		10f. Zip Code 21771		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) farm wife/ manager		16b. Kind of Business/Industry dairy						
17. Father's Name (First, Middle, Last) William Albert Horton				18. Mother's Name (First, Middle, Maiden Surname) Margaret Louise Stater						
19a. Informant's Name/Relationship (Type, Print) June E. Glisan/ daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12502 Old Annapolis Rd. Mt. Airy, MD 21771						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Central Cemetery		20c. Location - City or Town, State nr. Libertytown, MD				
21. Signature of Funeral Service Licensee <i>Catherine O. Hartzler</i>				22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Pneumonia</i> Due to (or as a consequence of): b. <i>Conjunctive Heart Failure</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Austin Pearre, Jr.</i>				29c. License number D09689		
				29d. Date signed (Month, Day, Year) 5/24/99						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, Jr. 300 W. 9th St. Frederick, MD 21701										
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature <i>Denise B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18656

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Louise Ganzmann				2. Date of Death Month Day Year May 25, 1999		3. Time of Death 15:28		
	4a. Facility Name (If not institution, give street and number) 123 Cherry Hill Road				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil		
Funeral Director	5. Social Security Number 212-16-0277		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) May 7, 1916		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 123 Cherry Hill Road		10f. Zip Code 21921		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) School Bus Driver	
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry Transportation		17. Father's Name (First, Middle, Last) William E. Ayers		18. Mother's Name (First, Middle, Maiden Surname) Bessie A. Smith		19a. Informant's Name/Relationship (Type, Print) Elaine Sheldon/ P.O.A.	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2874 Singerly Road, Elkton, Maryland 21921		20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cherry Hill Methodist Cemetery		20c. Location - City or Town, State Cherry Hill, Maryland		21. Signature of Funeral Service Licensee Donna S. Hicks	
22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, Maryland 21921		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finet disease or condition resulting in death) Interstitial Pulmonary Fibrosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medicot examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) May 25, 1999	
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier W. R. Renzulli M.D.		29c. License number D44102		29d. Date signed (Month, Day, Year) 5/27/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Renzulli, M.D. 901 Warburton Road, Elkton, Maryland 21921	
31. Date filed (Month, Day, Year) MAY 28 1999		32. Registrar's Signature B. Spade							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18657

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Galina L. Grabowski				2. Date of Death Month Day Year May 25, 1999				3. Time of Death 3:20pm	
	4a. Facility Name (If not institution, give street and number) 8811 Colesville Rd. Apt 1119				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 099-26-2078		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Nov 19, 1906		9. Birthplace (State or Foreign Country) Russia	
	Usual Residence of Decedent									
10a. State Md		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 8811 Colesville Rd. Apt 1119				10f. Zip Code 20910				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Editor				16b. Kind of Business/Industry McGraw-Hill Publishers		
17. Father's Name (First, Middle, Last) Leontiy Stashkewich				18. Mother's Name (First, Middle, Maiden Surname) Benigda Zelensky						
19a. Informant's Name/Relationship (Type, Print) Grand Tatiana Zinkevich/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6512 Ermin St. Burke, Va. 22015						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery				20c. Location - City or Town, State 5/28/99 Wash. D.C.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility PHILIP D. RINALDI FUNERAL SERVICE 11818 New Hampshire Ave. Silver Spg, Md.						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. AORTIC STENOSIS b. CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. d.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D24245		
29d. Date signed (Month, Day, Year) 5/26/99.				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ALAN DIAMOND, 10801 LOCKWOOD DR. SILVER SPRING, MD 20901						
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18658

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) VIVIAN GORDON				2. Date of Death Month MAY Day 21 Year 99		3. Time of Death 1:45 AM	
4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL				4b. City, Town, or Location of Death FORT WASHINGTON		4c. County of Death PRINCE GEORGES	
5. Social Security Number 238-62-7596		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) December 13, 1940	
9. Birthplace (State or Foreign Country) Henderson, N.C.		10a. State 20744		10b. County Prince George's		10c. City, Town or Location Fort Washington	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 906 Othman Drive		10f. Zip Code 20744		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Years: _____		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: _____		14. Race - American Indian, Black, White, etc. Specify: African-American	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) six years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Government		17. Father's Name (First, Middle, Last) George Vaughan	
18. Mother's Name (First, Middle, Maiden Summa) Janie Nelson		19a. Informant's Name/Relationship (Type, Print) Kirk A. Gordon - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 Othman Drive Ft. Washington, MD 20744		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____	
20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery 5/26/99		20c. Location - City or Town, State Suitland, MD		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd., N.E. Washington, D.C. 20019	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. Pancytopenia Due to (or as a consequence of): c. Chemotherapy Due to (or as a consequence of): d. Sarcoidosis		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Cystitis Oral Ulcers Thrombocytopenia		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
29c. License number D37066		29d. Date signed (Month, Day, Year) 05-21-99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uchehi CRAIG BECCU 4467 OLD BRANCH AVE. SUITE #105 Temple Hills Md 20748		31. Data filed (Month, Day, Year) MAY 25 1999	
32. Registrar's Signature 		33. State Registrar		34. State Registrar		35. State Registrar	

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

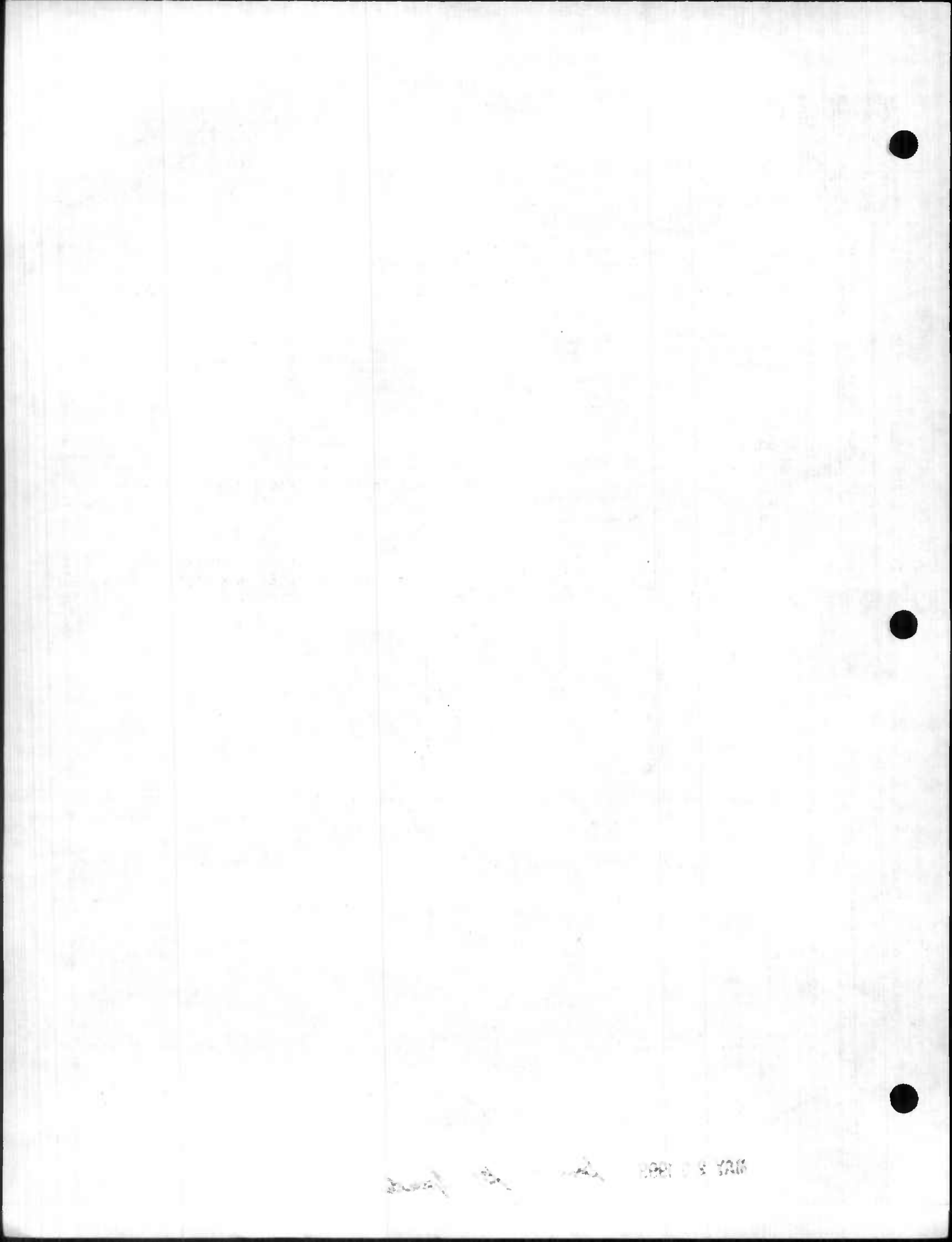
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

(5)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18659

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY LOUISE GRAY				2. Date of Death Month Day Year MAY 23, 1999		3. Time of Death 1700 p.m.	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 213 38 0870		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86	8. Date of Birth (Month, Day, Year) May 21 1913		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Calvert		10c. City, Town or Location Prince Frederick		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3460 Sixes Road				10f. Zip Code 20678		10g. Citizen of What Country? United States		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher/ administrator		16b. Kind of Business/Industry Public School		
17. Father's Name (First, Middle, Last) Luther Lafayette Gray				18. Mother's Name (First, Middle, Maiden Surname) Frances Dockett Williams				
19a. Informant's Name/Relationship (Type, Print) Nancy L. Porter- niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3450 Sixes Rd. Prince Frederick MD 20678				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Central Cemetery		Date May 27 1999		20c. Location - City or Town, State Prince Frederick Maryland		
21. Signature of Funeral Service Licensee B. Rausch				22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic Maryland 20676				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 2 yr 1								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Charles Bennett M.D.				29c. License number D 2556		29d. Date signed (Month, Day, Year) 5/24/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Charles Bennett, M.D. Prince Frederick, MD 20678								
31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature B. Sparks						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18660

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ISABEL

B.

GORE

2. Date of Death

Day Year

May 21, 1999

3. Time of Death

9:50 PM

4a. Facility Name (If not institution, give street and number)

228 Canal Park Dr Apt. 105

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

225-07-0013

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 7, 1914

9. Birthplace (State or Foreign Country)

Mexico

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

228 Canal Park Dr., Apt. 105

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

William Dozier Barnard

18. Mother's Name (First, Middle, Maiden Surname)

Hilda Soderberg

19a. Informant's Name/Relationship (Type, Print)

Dr. R.J. Gore Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1412 S. Salisbury Blvd. #4, Salisbury, MD 21801

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

5/22/99

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David A. Thompson

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cardiac arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

aortic stenosis

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles B. Silva Jr. MD

29c. License number

D30853

29d. Date signed (Month, Day, Year)

5/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles B. Silva Jr. MD 100 Power St. Salisbury MD 21804

31. Date filed (Month, Day, Year)

MAY 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials.

ERRI & S YAM

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18661

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MATTIE HARRIS				2. Date of Death Month Day Year MAY 20 1999		3. Time of Death 1725		
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 358-16-7863		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 12 1914		
	9. Birthplace (State or Foreign Country) N. CAROLINA								
Usual Residence of Decedent									
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location SEVERNA PARK			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 809 OLD COUNTY ROAD				10f. Zip Code 21146		10g. Citizen of What Country? US			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4 yrs.				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES MANAGER		16b. Kind of Business/Industry STANLEY HOME PRODUCTS			
17. Father's Name (First, Middle, Last) KEIFFER POWELL					18. Mother's Name (First, Middle, Maiden Surname) JANIE SAUNDERS				
19a. Informant's Name/Relationship (Type, Print) RANDOLPH SCOTT (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11701 LOCUST GLEN DR. MITCHELLVILLE, MD. 20721					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) cedar hill cemetery		Date 5/26/99		20c. Location - City or Town, State BROOKLYN, MD.		
21. Signature of Funeral Service Licensee Harry H. Reese				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiomyopathy Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Pneumonia Dehydration						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier [Signature]				29c. License number 032036		29d. Date signed (Month, Day, Year) 5/26/99			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Gary J. Sprau 2108 D. Bonab Drive Chester, MD 21619									
31. Date filed (Month, Day, Year) MAY 26 1999			32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18662

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ashlee J. Hopewell						2. Date of Death Month May Day 18 Year 1999		3. Time of Death 9:55PM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital						4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number N/A		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. _____	If Under 1 Year Months _____ Days _____	If Under 24 Hrs. Hours _____ Min. _____	8. Date of Birth (Month, Day, Year) May 18, 1999		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Prince Georges'		10c. City, Town or Location Laurel				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 13016 Old Stage Coach Road				10f. Zip Code 20708			10g. Citizen of What Country? United States			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A			16b. Kind of Business/Industry N/A			
17. Father's Name (First, Middle, Last) LeAnton S. Hopewell						18. Mother's Name (First, Middle, Maiden Surname) Shellita Carney				
19a. Informant's Name/Relationship (Type, Print) Shellita Carney-Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13016 Old Stage Coach Road, Laurel, Maryland 20708						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 5-27-99		20c. Location - City or Town, State Brentwood, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Immaturity Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. _____ Due to (or as a consequence of): d. _____ Due to (or as a consequence of):										Approximate Interval Between Onset and Death 1 hour
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M _____		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner				29c. License number D35007						
29b. Signature and title of certifier 				29d. Date signed (Month, Day, Year) 5/19/99						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Paul Lewis MD 1500 Forest Glen Rd Silver Spring MD 20910										
31. Date filed (Month, Day, Year) MAY 25 1999				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1944

1944

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #1, Per Phy.

State of Maryland / Department of Health and Mental Hygiene

5/25/99, Carroll County, wjl

Certificate of Death

Reg. No.

99 48663

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Robert G. Holmes, Sr.</u>			2. Date of Death Month <u>5</u> Day <u>23</u> Year <u>99</u>			3. Time of Death <u>6:45 AM</u>			
	4a. Facility Name (If not institution, give street and number) <u>Carroll Northern Village Nursing Home</u>			4b. City, Town, or Location of Death <u>Westminster</u>			4c. County of Death <u>Carroll</u>			
Funeral Director	5. Social Security Number <u>214-18-1430</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>77</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Mar 1 1922</u>		9. Birthplace (State or Foreign Country) <u>MD</u>	
	10a. State <u>MD</u>			10b. County <u>Carroll</u>		10c. City, Town or Location <u>Westminster</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <u>20 Kalten Road</u>			10f. Zip Code <u>21158</u>			10g. Citizen of What Country? <u>USA</u>			
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>1942 -</u> If Yes, Give Year or Dates: <u>1945</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> Collage (1-4 or 5+) <u></u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Salesman</u>			16b. Kind of Business/Industry <u>Wagner Brothers Containers, Inc.</u>			
	17. Father's Name (First, Middle, Last) <u>Raymond Holmes</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Julia Bell</u>						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Marian Holmes/wife</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>20 Kalten Road Westminster, MD 21158</u>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>entombment</u>			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Loudon Park Cem</u>			20c. Location - City or Town, State <u>5/26/99 Baltimore, MD</u>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <u>John K. A. [Signature]</u>			22. Name and Address of Facility <u>Pritts Funeral Home & Chapel</u> <u>412 Washington Road Westminster, MD 21157</u>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Sepsis</u> Due to (or as a consequence of): b. <u>Aspiration Pneumonia</u> Due to (or as a consequence of): c. <u></u> Due to (or as a consequence of): d. <u></u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death <u>4 days</u> <u>4 days</u>						
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>BCVAE Hemiplegia, Dysphagia</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <u>[Signature]</u>			29c. License number <u>D37949</u>		29d. Date signed (Month, Day, Year) <u>May 24th 1999</u>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Alexander Boychukewsky 205 St. Mark Way Westminster, MD, 21157</u>			31. Data filed (Month, Day, Year) <u>MAY 25 1999</u>						
State Registrar	32. Registrar's Signature <u>Bernice G. Sparks</u>									

Baltimore, Maryland 21215-0020

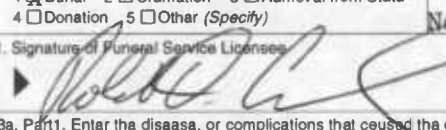
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18664

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KENNETH LEWIS HAINES SR.				2. Date of Death Month 5 Day 25 Year 1999		3. Time of Death 2000	
	4a. Facility Name (If not institution, give street and number) Union Hospital of Cecil County				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 007-32-6201		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 28, 1934	9. Birthplace (State or Foreign Country) Maine
	Usual Residence of Decedent							
10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 14 Wilderness Road				10f. Zip Code 21921		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give US Army Year or Dates: 1953-1973		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Guard			16b. Kind of Business/Industry Hotel	
17. Father's Name (First, Middle, Last) Keene Haines				18. Mother's Name (First, Middle, Maiden Surname) Myrtle McCall				
19a. Informant's Name/Relationship (Type, Print) Nancy Ann Haines / Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Wilderness Road, Elkton, MD 21921				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cem.		Date May 28 1999		20c. Location - City or Town, State North East, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Pneumonia and chronic pleuritis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease Renal Artery Stenosis Meningioma Hypertension Chronic Renal Failure								Approximate Interval Between Onset and Death Days Days
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner		29b. Signature and title of certifier 						
29c. License number 130291		29d. Date signed (Month, Day, Year) 5/26/99						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Denitzio, M.D., 111 West High Street, Elkton, MD 21921 410-392-3007								
31. Date filed (Month, Day, Year) MAY 28 1999		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

99 18665

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAZEL HINES				2. Date of Death Month MAY Day 23 Year 1999				3. Time of Death unk.	
	4a. Facility Name (If not institution, give street and number) 1010 PALMER ROAD				4b. City, Town, or Location of Death FORT WASHINGTON				4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 054-42-6198		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) OCT 16, 1941		9. Birthplace (State or Foreign Country) PANAMA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County PRINCE GEORGES		10c. City, Town or Location FORT WASHINGTON				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1010 PALMER RD				10f. Zip Code 20744		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME HEALTH AIDE				16b. Kind of Business/Industry HEALTHCARE			
	17. Father's Name (First, Middle, Last) Unk. WHYTE				18. Mother's Name (First, Middle, Maiden Surname) ROSE FORBES					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JONALISA THOMPSON / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 PALMER RD., FORT WASHINGTON, MD 20744					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RESURRECTION CEMETERY		Data 5-28-99		20c. Location - City or Town, State CLINTON, MD			
	21. Signature of Funeral Service Licensee <i>Larry L. Simmons</i>				22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME 5538 MARLBORO PIKE, FORESTVILLE, MD 20747					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARRYTHMIA Due to (or as a consequence of): b. CARDIOMYOPATHY Due to (or as a consequence of): c. CHF Due to (or as a consequence of): d. HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death MINUTES	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number D 32800		29d. Date signed (Month, Day, Year) MAY 25, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. WASHINGTON M.D. FORT WASHINGTON HOSPITAL #205										
State Registrar	31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18666

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary C. Harris						2. Date of Death Month Day Year May 19, 1999		3. Time of Death 6:33 PM	
	4a. Facility Name (If not institution, give street and number) 2606 Kinderbrook Lane						4b. City, Town, or Location of Death Bowie		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 216-44-7089		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 91		8. Date of Birth (Month, Day, Year) Aug. 24, 1907		9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent									
10a. State MD		10b. County Prince Georges		10c. City, Town or Location Bowie				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 2606 Kinderbrook Lane				10f. Zip Code 20715			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor			16b. Kind of Business/Industry U.S. Department of State		
17. Father's Name (First, Middle, Last) Alfred R. Cobbs						18. Mother's Name (First, Middle, Maiden Surname) Lauretta Bennett				
19a. Informant's Name/Relationship (Type, Print) Mary Anne Krend/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2606 Kinderbrook Lane Bowie, Md. 20715				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Curlew Hills Memory Gardens			Date 05-24-99		20c. Location - City or Town, State Palm Harbor, Florida		
21. Signature of Funeral Service Licensee Shannon W. Ramirez Shannon W. Ramirez M00798						22. Name and Address of Facility BEALL FUNERAL HOME 6512 N.W. Crain Highway Bowie, Md. 20715				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) a. Metastatic Carcinoma months Due to (or as a consequence of): b. Carcinoma of the breast Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier David M. Goldman						29c. License number DO4374		29d. Date signed (Month, Day, Year) 5-24-99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID M GOLDMAN 7500 HANOVER PKWAY, GREENBELT, 20770 Md.										
31. Date filed (Month, Day, Year) MAY 24 1999			32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

edham

Proclamation of the President
of the United States

1842

1842

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #5 per F.H. 5/25/1999 WCHD

Certificate of Death

Reg. No.

99 18667

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Edward Horner, Jr.				2. Date of Death Month Day Year May 11, 1999		3. Time of Death 6:35 PM	
	4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare				4b. City, Town, or Location of Death Salisbury, MD		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 220-01-8294		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9-2-1920	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD		10b. County Wicomico		10c. City, Town or Location Willards			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 36405 Old Ocean City Road				10f. Zip Code 21874		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Dates If Yes, Give Year or Dates: Unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Guard			16b. Kind of Business/Industry Lumber Co.	
17. Father's Name (First, Middle, Last) Charles E. Horner, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Brown				
19a. Informant's Name/Relationship (Type, Print) Stella E. Smith, Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 66, Showell, MD 21862				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Data 5-17-99		20c. Location - City or Town, State Salisbury, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Messick Funeral Home, P.O. Box 61, Bivalve, MD 21814				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Bronchospasm Spoke Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 days 4 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. D. Diabetes						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury or Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of Certifier 				29c. License number D 39813		29d. Date signed (Month, Day, Year) 5/4/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804								
31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

9991 8 S YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

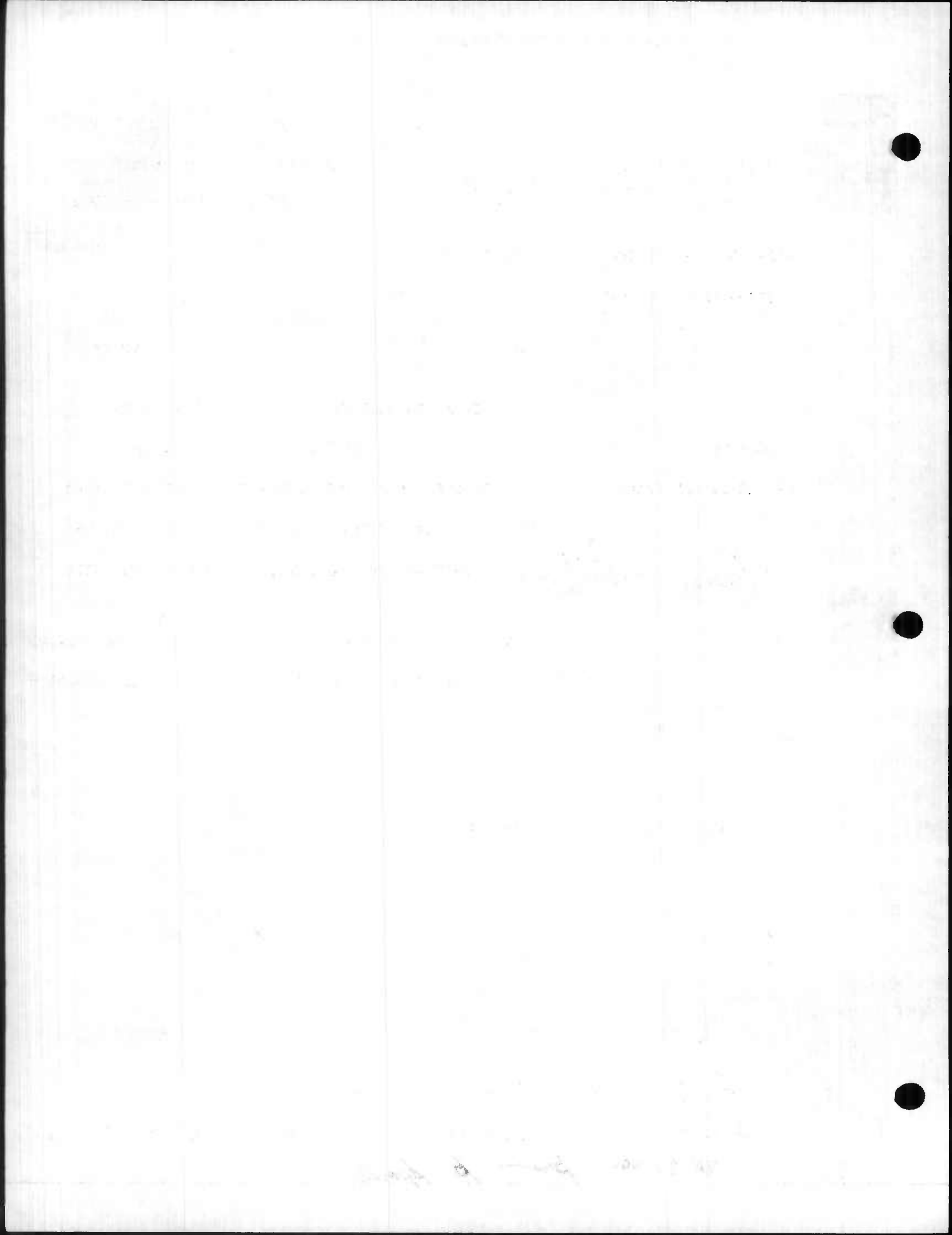
Reg. No.

99 18668

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES ALVIN HALL JR.		2. Date of Death Month: MAY Day: 21 Year: 1999		3. Time of Death 12:17
	4a. Facility Name (If not institution, give street and number) 13306 COLONIAL ROAD		4b. City, Town, or Location of Death OCEAN CITY		4c. County of Death WORCESTER
Funeral Director	5. Social Security Number 222-14-6247	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth (Month, Day, Year) APRIL 10, 1926	
	9. Birthplace (State or Foreign Country) DELAWARE		10. Usual Residence of Decedent 10a. State: MARYLAND 10b. County: WORCESTER 10c. City, Town or Location: OCEAN CITY 10d. Inside City Limits: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 13306 COLONIAL ROAD		10f. Zip Code 21842		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PLANNING ANALYST		16b. Kind of Business/Industry OIL REFINERY		
	17. Father's Name (First, Middle, Last) CHARLES HALL		18. Mother's Name (First, Middle, Maiden Surname) MYRTLE L. HEMPHILL		
	19a. Informant's Name/Relationship (Type, Print) MYRTLE J. HALL/WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13306 COLONIAL ROAD, OCEAN CITY, MARYLAND 21842		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DELAWARE CITY CEMETERY		20c. Location - City or Town, State 5/25/99 DELAWARE CITY, DE
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CORONARY OCCLUSION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RECENT BY-PASS SURGERY				
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D 06241		29d. Date signed (Month, Day, Year) 5-21-99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21863					
31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18669

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy G. Hopkins

2. Date of Death

May 21 1999 12:50 p.m.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Deer's Head Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

125-09-0655

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 28, 1920

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1139 S. Division St.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Leonard Francis

18. Mother's Name (First, Middle, Maiden Surname)

Priscilla Eustace

19a. Informant's Name/Relationship (Type, Print)

Dorothy Ann Bradshaw/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5312 River Dr., Cambridge, MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wicomico Memorial Park

Date

5/25/99

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David H. Thompson MDIOSI

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Carcinoma of ovary

Approximate Interval Between Onset and Death

11 days

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

X

29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Virginia A. Dulany MD

29c. License number

D33905

29d. Date signed (Month, Day, Year)

5/21/99

30. Name and address of person who completed cause of death (If on 23a) (Type, Print)

Virginia A. Dulany, M.D., CMD, P.O. Box 2018, Salisbury, MD 21802-2018

31. Date filed (Month, Day, Year)

MAY 24 1999

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

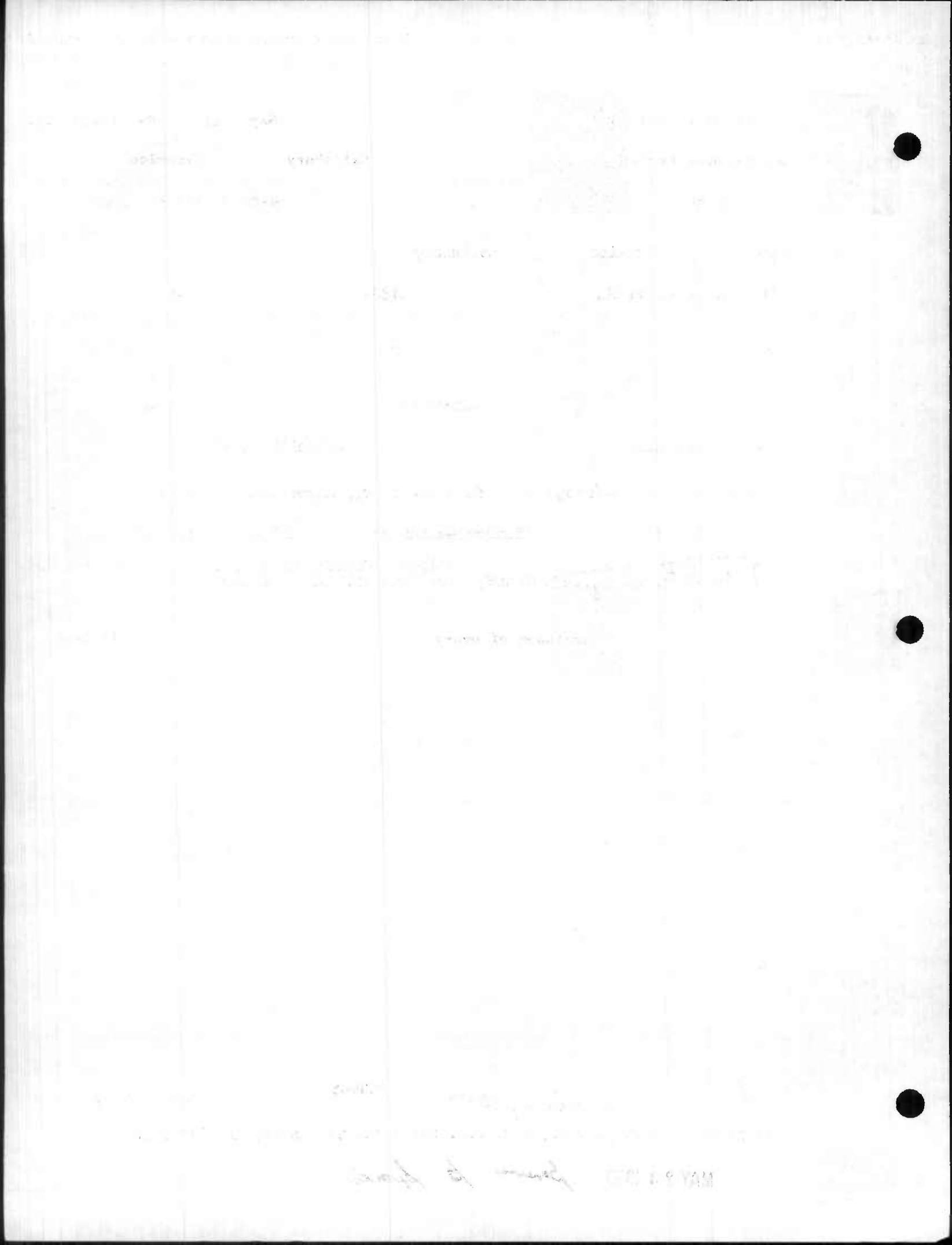
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18670

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN E. HUDSON

2. Date of Death
Month Day Year
MAY 24 1999

3. Time of Death
9:50 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

BERLIN NURSING & REHABILITATION CENTER

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

5. Social Security Number

221-50-1818

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

AUG. 17, 1900

9. Birthplace (State or Foreign Country)

DELAWARE

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

SELBYVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

51 MCCABE STREET

10f. Zip Code

19975

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LEVIN E. MILLER

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE PEPPER

19a. Informant's Name/Relationship (Type, Print)

HELEN H. JOHNSON/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 537, SELBYVILLE, DELAWARE 19975

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BISHOPVILLE CEMETERY

Date

5/28/99

20c. Location - City or Town, State

BISHOPVILLE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic Cardiovascular Disease*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Essential Hypertension

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

5-25-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DRIVE, SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

MAY 26 1999

32. Registrar's Signature

[Signature]

State
Registrar

HELEN HUDSON

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

[Handwritten signature] 1991 J S YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18671

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elmer Harry Irwin				2. Date of Death Month Day Year May 27, 1999		3. Time of Death 9:19 am		
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 578-30-1907		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 25, 1927		
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Private Industry	
17. Father's Name (First, Middle, Last) John Clyde Irwin				18. Mother's Name (First, Middle, Maiden Surname) Margaret Marie Hutsler				19a. Informant's Name/Relationship (Type, Print) Donald Irwin - Son	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8213 Cedar Street, Silver Spring, Maryland 20910				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State Brentwood, Maryland	
21. Signature of Funeral Service Licensee <i>Carlynn Gasch - Brady</i>				22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory arrest Due to (or as a consequence of): Aspiration pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cerebrovascular accident Seizure disorder	
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier <i>Ameli</i>				29c. License number D19609				29d. Date signed (Month, Day, Year) May 28, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman R. Tuli, M.D. 3503 Perry Street, #B, Mount Rainier, Maryland 20712-2141				31. Date filed (Month, Day, Year) MAY 28 1999				32. Registrar's Signature <i>B. Sparks</i>	

To Be Completed by Funeral Director

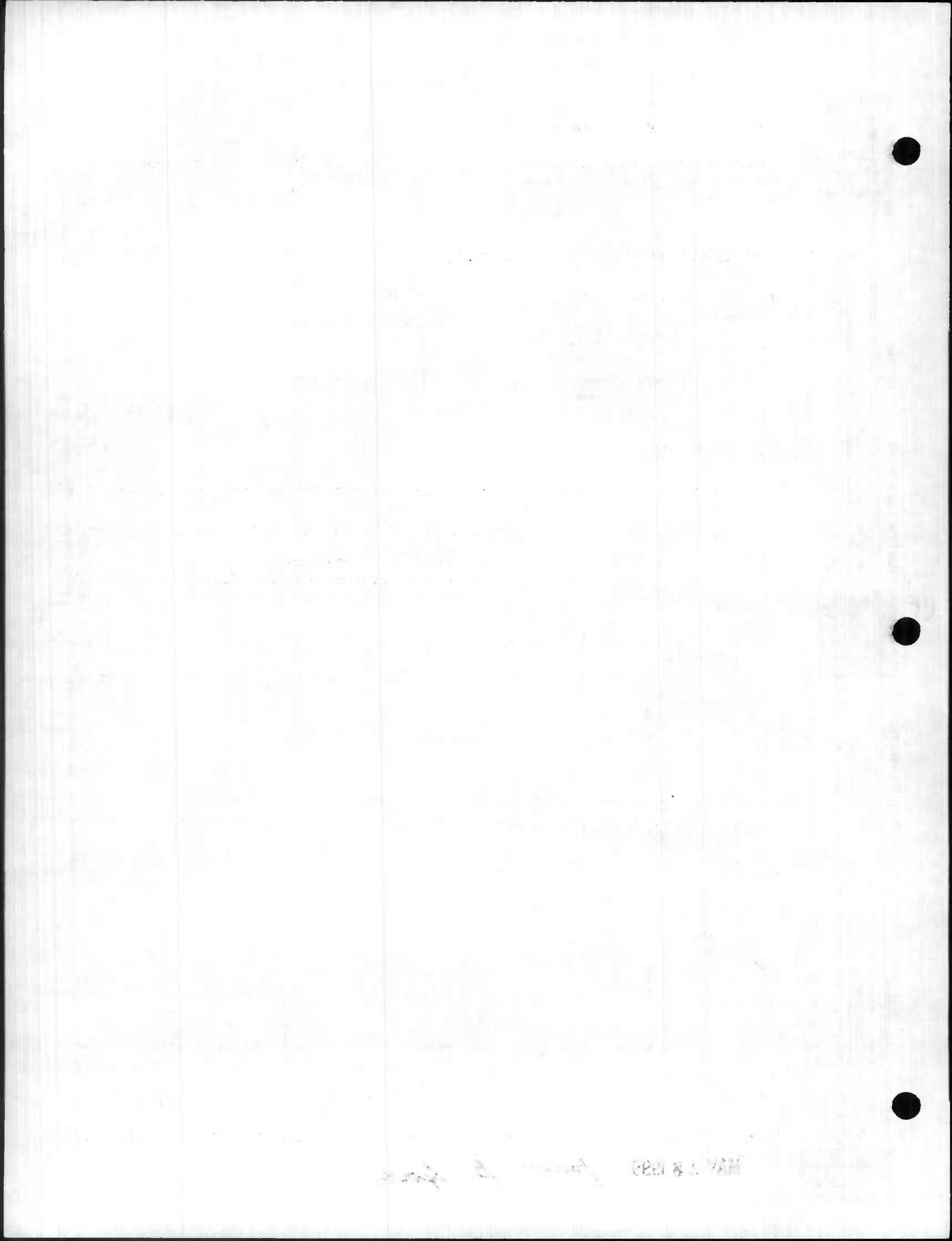
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified in writing.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



000 8 1 YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18672

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stella Johnson				2. Date of Death Month MAY Day 25 Year 99		3. Time of Death 1255		
	4a. Facility Name (If not Institution, give street and number) 7857 Americana Cir T-3				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death AA		
Funeral Director	5. Social Security Number 213-36-5436	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 10 1922		9. Birthplace (State or Foreign Country) MARYLAND	
	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 7857 AMERICANA CIRCLE APT. T 3				10f. Zip Code 21060		10g. Citizen of What Country? US		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTODIAN		16b. Kind of Business/Industry ANNE ARUNDEL COMMUNITY COLLEGE				
	17. Father's Name (First, Middle, Last) JOHN SOMMERVILLE				18. Mother's Name (First, Middle, Maiden Surname) LUVENIA JACKSON				
	19a. Informant's Name/Relationship (Type, Print) CYNTHIA DAY (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7857 AMERICANA CIRCLE APT. T3 MD. 21060				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CARPENTER HILL CEME.		Date 6/1/99		20c. Location - City or Town, State ROUND BAY, MD.		
	21. Signature of Funeral Service Licensee Harry D. Reese		22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Heart Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Deputy William P. Jones, MD				29c. License number DD6054		29d. Date signed (Month, Day, Year) 5/25/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 Americana 21035									
31. Date filed (Month, Day, Year) JUN 01 1999		32. Registrar's Signature Benjamin B. Apantaku							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the document is a list of names and addresses, which are arranged in a columnar format. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into three columns, with the names in the first column, the addresses in the second column, and the names in the third column.

2. The second part of the document is a list of names and addresses, which are arranged in a columnar format. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into three columns, with the names in the first column, the addresses in the second column, and the names in the third column.

3. The third part of the document is a list of names and addresses, which are arranged in a columnar format. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into three columns, with the names in the first column, the addresses in the second column, and the names in the third column.

4. The fourth part of the document is a list of names and addresses, which are arranged in a columnar format. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into three columns, with the names in the first column, the addresses in the second column, and the names in the third column.

5. The fifth part of the document is a list of names and addresses, which are arranged in a columnar format. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into three columns, with the names in the first column, the addresses in the second column, and the names in the third column.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18673

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID LYNN JOHNSON				2. Date of Death Month Day Year MAY 21, 1999		3. Time of Death 2:14 pm	
	4a. Facility Name (If not Institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 364-60-4253		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10-15-1956	9. Birthplace (State or Foreign Country) MICHIGAN
	Usual Residence of Decedent							
10a. State MD		10b. County PRINCE GEORGES		10c. City, Town or Location LANDOVER			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3006 BRIGHTSEAT ROAD, #102				10f. Zip Code 20786		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STOCKER			16b. Kind of Business/Industry WAREHOUSE	
17. Father's Name (First, Middle, Last) JAMES JOHNSON					18. Mother's Name (First, Middle, Maiden Surname) GRACE LOUISE WARE			
19a. Informant's Name/Relationship (Type, Print) ANTHONY JOHNSON - BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 MONTELLO AVE., NE WASH. DC 20002				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE PARK CREM.		20c. Location - City or Town, State 28-1999 RIVERDALE, MD		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. DC 20001				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Systemic Inflammatory Response Syndrome Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Pneumonia Due to (or as a consequence of): d. Brain Masses								Approximate Interval Between Onset and Death Days Days Days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cirrhosis Hepatitis C						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> M.D.		29c. License number 03 0318		29d. Date signed (Month, Day, Year) 5/26/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JAMES CATAVENIS - 3001 HOSPITAL DRIVE, CHEVERLY, MD								
31. Date filed (Month, Day, Year) MAY 28 1999		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Page 100 of 100

1. The first part of the document is a list of names and addresses.

2. The second part of the document is a list of names and addresses.

3. The third part of the document is a list of names and addresses.

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26. The twenty-sixth part of the document is a list of names and addresses.

27. The twenty-seventh part of the document is a list of names and addresses.

28. The twenty-eighth part of the document is a list of names and addresses.

29. The twenty-ninth part of the document is a list of names and addresses.

30. The thirtieth part of the document is a list of names and addresses.

99 18674

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hattie Mae Jackson				2. DATE OF DEATH MONTH DAY YEAR May 23, 1999				3. TIME OF DEATH M 3:05 AM	
4. SOCIAL SECURITY NUMBER 579-52-2881		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS 2/7/39		IF UNDER 24 HRS. HOURS MIN. 2/7/39	
9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Clinton				9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY P.G.		10c. CITY, TOWN OR LOCATION Hillcrest Hgts.				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3403 26th Avenue				10f. ZIP CODE 20748				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Apartment Manager				16b. KIND OF BUSINESS/INDUSTRY Real Estate	
17. FATHER'S NAME (First, Middle, Last) Troy Durant				18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Latson					
19a. INFORMANT'S NAME (Type/Print) Osley Silas, Jr./Son				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4549 Natahala Dr., Clinton, Md., 20735					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc. 5/29/99				20c. LOCATION — City or Town, State Beltsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry N. Pratt</i>				22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Asystole</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Diabetes</i> Due to (or as a consequence of): c. <i>Cervical Cancer</i> Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <i>Unknown</i> <i>Unknown</i> <i>Unknown</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. G. Smith MD</i>				29c. LICENSE NUMBER DS0454	
29d. DATE SIGNED (Month, Day, Year) May 23, 1999				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRASCO YAZDANI M.D. 7700 Old Branch Rd AC-101 Clinton, MD 20735					
31. DATE FILED (Month, Day, Year) MAY 27 1999				REGISTRAR'S SIGNATURE <i>Berna B. Sparks</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18675

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nathan Lee Johnson				2. Date of Death Month Day Year MAY 21, 1999				3. Time of Death 0322 AM		
	4a. Facility Name (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death WESTMINSTER				4c. County of Death CARROLL		
Funeral Director	5. Social Security Number 579-80-4122		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) Sept 13 1958		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State Md		10b. County Carroll		10c. City, Town or Location Sykesville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 6655 Sykesville Road				10f. Zip Code 21784				10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) never worked				16b. Kind of Business/Industry none			
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Johnson							
19a. Informant's Name/Relationship (Type, Print) Scott Yewell LPN (caregiver)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prologue, 6655 Sykesville Rd. Sykesville Md 21784							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Springfield Cemetery		Date 5-27-99		20c. Location - City or Town, State Sykesville, Md			
21. Signature of Funeral Service Licensee ► Paige Haight Herbert				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Malignant T-cell Lymphoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Schizophrenia Hypertensive Cardiovascular Disease Diabetes Mellitus										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier ► J. Pestaner, M.D.				29c. License number O.C.M.E				29d. Date signed (Month, Day, Year) MAY 21, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18676

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Braby Jones

2. Date of Death

Month Day Year
MAY 26 1999

3. Time of Death

7:17 A.M.

4a. Facility Name (If not institution, give street and number)

MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

484-18-9031

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 13, 1923

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3906 Brinkley Rd.

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No 1944-
If Yes, Give
Year or Dates: 6713. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Meteorologist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Lewis Jones

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Braby

19a. Informant's Name/Relationship (Type, Print)

Alma Bauch Jones/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3906 Brinkley Rd., Temple Hills, MD 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cemetery 6/8/99 Arlington, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home, P.A.
6160 Oxon Hill Rd., Oxon Hill, MD 2074523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC NON-HODGKIN'S LYMPHOMA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MENINGIOMA OF THE BRAIN

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George P. Kalas Medical Doctor

29c. License number

96-00232

29d. Date signed (Month, Day, Year)

MAY 26 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYLENE HUYNH, MAJ, USAF, MC

89 MDG/1050 W PERIMETER ROAD

ANDREWS AIR FORCE BASE MD 20762

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

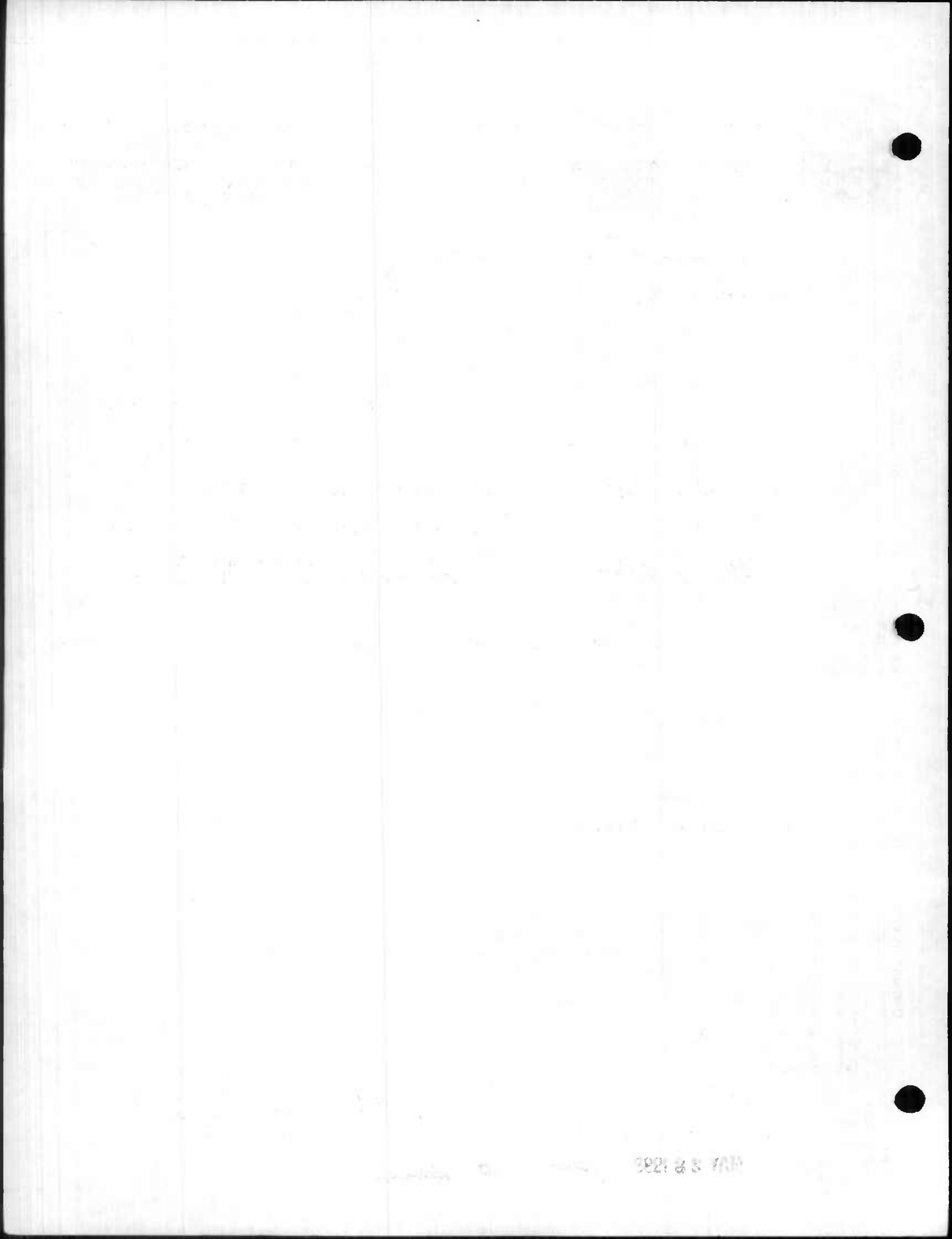
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18677

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM M. JOHNSON				2. Date of Death Month 05 Day 23 Year 99		3. Time of Death 9:00 pm	
	4a. Facility Name (If not institution, give street and number) Regency Health Services				4b. City, Town, or Location of Death Forestville		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 217-18-2199		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 02, 1922	9. Birthplace (State or Foreign Country) Washington, D.C.
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Forestville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 4417 Rena Road, Apt #203				10f. Zip Code 20747		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Private		
17. Father's Name (First, Middle, Last) Lawrence Johnson				18. Mother's Name (First, Middle, Maiden Surname) Viola Manley				
19a. Informant's Name/Relationship (Type, Print) Juanda A. Johnson-Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4432 68th Place, #B-7, Landover, Maryland 20785				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		Date 06/01 1999		20c. Location - City or Town, State Cheltenham, Maryland		
21. Signature of Funeral Service Licensee Nancy A. Perante				22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier George C. Hajjar, Jr.				29c. License number 039550		29d. Date signed (Month, Day, Year) 5-25-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lantana, Md. 20706								
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature Bruce B. Spate				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten signature

PERI & C YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18678

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MENTRE MARVIS LESTER JAMES

2. Date of Death

May 20 1999

3. Time of Death

6:45pm

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE'S HOSPITAL CENTER

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's Co

5. Social Security Number

223-26-6657

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 13, 16

9. Birthplace (State or Foreign Country)

North Car

Usual Residence of Decedent

10e. State

MD

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

2 ☒ Yes 2 ☐ No

10e. Street and Number

601 Halifax Place

10f. Zip Code

20774

10g. Citizen of What Country?

United States America

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Food Service Manager

16b. Kind of Business/Industry

State Government

17. Father's Name (First, Middle, Last)

Arthur Chester

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Powell

19a. Informant's Name/Relationship (Type, Print)

Rosalind T. James - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

601 Halifax Place; Upper Marlboro, Md. 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

5/26/99

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Glenda M. Freeman

22. Name and Address of Facility

Robert O. Freeman Funeral Svcs

1353 H Street, N.E.; Washington, D.C. 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Severe Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

XIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Myocardial Infarction

Due to (or as a consequence of):

h/s

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dehydration

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. JAVARON

29c. License number

D41978

29d. Date signed (Month, Day, Year)

5-21-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. JAVARON

PGH Cheverly MD 20785

State
Registrar

31. Date filed (Month, Day, Year)

MAY 24 1999

32. Registrar's Signature

B. JAVARON

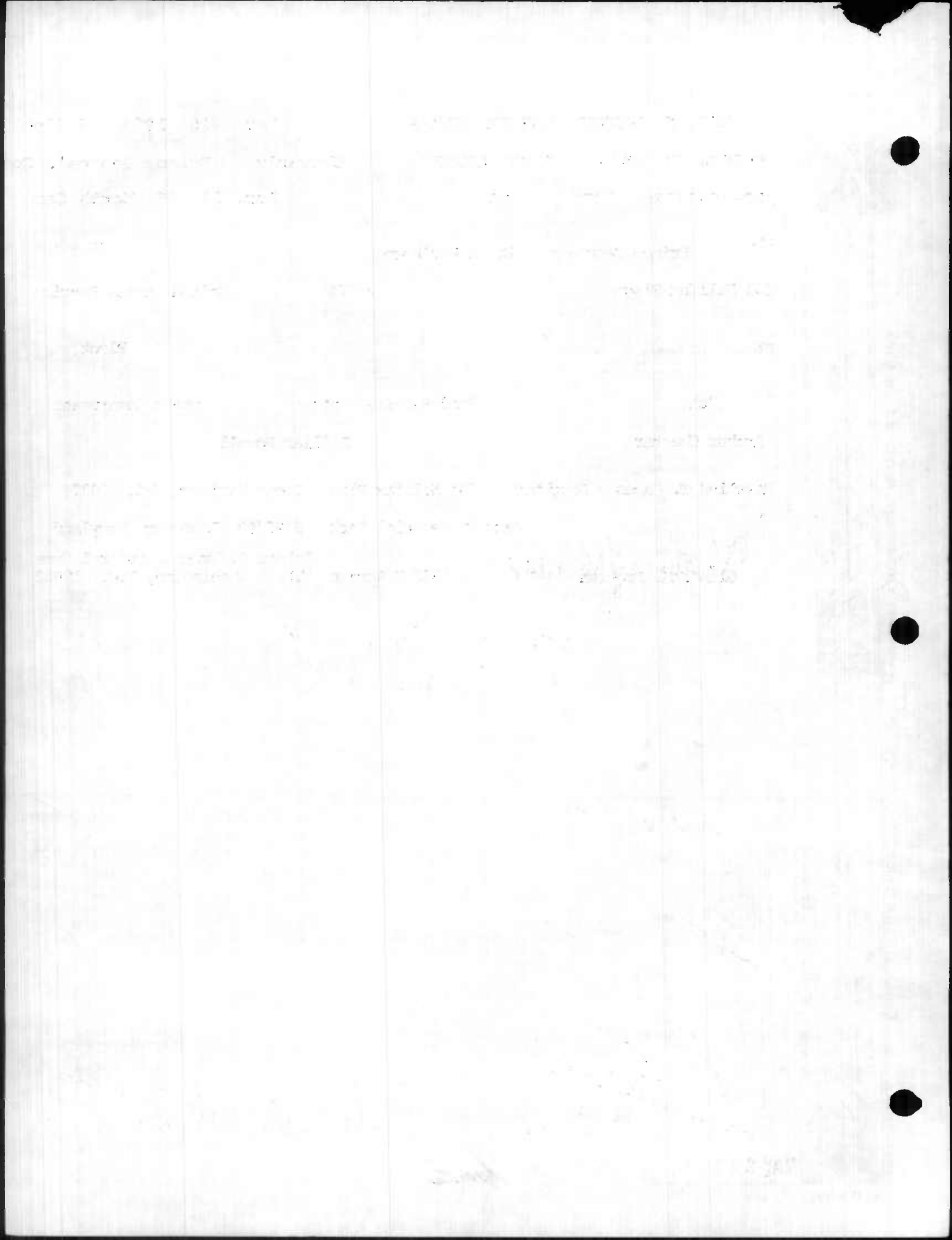
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18679

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THEODORE JOHNSON				2. Date of Death Month Day Year May 19, 1999		3. Time of Death 6:46 PM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-16-7056		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) July 3, 1922	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State D.C.		10b. County N/A		10c. City, Town or Location Washington	
10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 3910 13th Street N.W.		10f. Zip Code 20011		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1942-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chauffer		16b. Kind of Business/Industry Navy Dept.				
17. Father's Name (First, Middle, Last) Nathan Johnson				18. Mother's Name (First, Middle, Maiden Surname) Alice McIver				
19a. Informant's Name/Relationship (Type, Print) Mildred E. Johnson - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3910 13th Street N.W., Washington, DC 20011				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cem.		20c. Location - City or Town, State 5-25-99 Suitland, MD				
21. Signature of Funeral Service Licensee J. P. Marshall				22. Name and Address of Facility Marshall's Funeral Home, Inc. 4308 Suitland Road, Suitland, MD 20746				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. CARDIAC ARRHYTHMIA Due to (or as a consequence of): c. ASPIRATION PNEUMONIA Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death DAYS. WEEKS. DAYS.				
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. END STAGE RENAL FAILURE.				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No						
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. P. Marshall, D.		29c. License number D48290		29d. Date signed (Month, Day, Year) MAY 20, 1999.		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARLOS E. COVARRUBIAS 8121 GEORGIA AVE. #405 SILVER SPRING, MD 20910								
31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature Benjamin B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99-18680

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARTHA ROBERTA JONES		2. Date of Death Month Day Year May 21 1999		3. Time of Death 2230
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 218-24-5077	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) JUNE 18, 1910		9. Birthplace (State or Foreign Country) MARYLAND		
Usual Residence of Decedent					
10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location SALISBURY	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 218 MONTICELLO AVE.		10f. Zip Code 21801		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR OF INSTRUCTION		16b. Kind of Business/Industry BD OF EDUCATION	
17. Father's Name (First, Middle, Last) T. RODNEY JONES		18. Mother's Name (First, Middle, Maiden Surname) JULIA WALLER			
19a. Informant's Name/Relationship (Type, Print) RUTH T. DONAWAY		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31854 DAGSBORO RD. DELMAR, MD 21875			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PARSONS CEMETERY		20c. Location - City or Town, State 5/25/99 SALISBURY, MARYLAND	
21. Signature of Funeral Service Licensee B. Keitt A. Higgins, CFSP		22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. Acute Pulmonary edema - Due to (or as a consequence of):			Approximate Interval Between Onset and Death 3h
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Chronic Congestive Heart Failure - Due to (or as a consequence of):			10yrs
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinsonism					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Joseph R. Barros, M.D.		29c. License number D15192		29d. Date signed (Month, Day, Year) 5/25/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Barros, M.D. 813 B EASTERN SHORE DR. SALISBURY, MD 21804					
31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature B. Sparks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

MAY 2 1955

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18681

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JESSIE BENJAMIN KINDLEY, JR.				2. Date of Death Month Day Year MAY 21, 1999		3. Time of Death 1825 PM	
	4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL E.R.				4b. City, Town, or Location of Death FORT WASHINGTON		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 218 86 6549		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 31 Yrs.		8. Date of Birth (Month, Day, Year) July 21, 1967	
	9. Birthplace (State or Foreign Country) Washington D.C.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bladensburg	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4408 54th Place		10f. Zip Code 20710		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Holiday Inn			
	17. Father's Name (First, Middle, Last) Jessie B. Kindley				18. Mother's Name (First, Middle, Maiden Surname) Phyllis Ball			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Phyllis A. Gray /Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6927 Forest Terrace Landover, MD 20785			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, MD		20d. Date 5-28	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Kimberly C. Buscetta-Tonic</i>				22. Name and Address of Facility MARSHALL'S FUNERAL HOME 4217 Ninth Street NW Washington D.C. 20011			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 5/21/99		28b. Time of Injury 1:49 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred motorcycle operator collides with vehicle		28e. Location (Street and Number or Rural Route Number, City or Town, State) Street 5200 Livingston Rd; Oxon Hill, Md.					
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>J. Pestaner M.D.</i>				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MAY 23, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 11 Penn Street, Baltimore, Maryland 21201							
State Registrar	31. Date filed (Month, Day, Year) MAY 27 1999				32. Registrar's Signature <i>Spencer B. Sparks</i>			

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18682

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nicholas John Kamit				2. Date of Death Month Day Year MAY 26, 1999		3. Time of Death 7:54 A.M.									
	4a. Facility Name (If not institution, give street and number) VA MARYLAND HEALTH CARE SYSTEM				4b. City, Town, or Location of Death PERRY POINT		4c. County of Death CECIL									
Funeral Director	5. Social Security Number 189-22-3335		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) December 14, 1921									
	9. Birthplace (State or Foreign Country) Pennsylvania		10e. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton									
Usual Residence of Decedent		10e. Street and Number 106 Jarmon Road		10f. Zip Code 21921		10g. Citizen of What Country? United States										
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1939-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry College												
17. Father's Name (First, Middle, Last) Petro Kmit				18. Mother's Name (First, Middle, Maiden Surname) Anna Kisera												
19a. Informant's Name/Relationship (Type, Print) Kathy A. Thacker / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87 Brownfield Loop, Elkton, Maryland 21921												
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Delaware Veterans Memorial Cemetery		Date 6/1/99		20c. Location - City or Town, State Bear, Delaware										
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland												
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e. RECURRENT PNEUMONIA Due to (or as a consequence of):</td> <td>1 DAY</td> </tr> <tr> <td>b. DIFFICULTY SWALLOWING Due to (or as a consequence of):</td> <td>7 MONTHS</td> </tr> <tr> <td>c. CARDIOVASCULAR ACCIDENT Due to (or as a consequence of):</td> <td>7 MONTHS</td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. RECURRENT PNEUMONIA Due to (or as a consequence of):	1 DAY	b. DIFFICULTY SWALLOWING Due to (or as a consequence of):	7 MONTHS	c. CARDIOVASCULAR ACCIDENT Due to (or as a consequence of):	7 MONTHS	d. _____	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. RECURRENT PNEUMONIA Due to (or as a consequence of):	1 DAY														
	b. DIFFICULTY SWALLOWING Due to (or as a consequence of):	7 MONTHS														
	c. CARDIOVASCULAR ACCIDENT Due to (or as a consequence of):	7 MONTHS														
	d. _____															
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred														
28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. Signature and title of certifier 				29c. License number D30951		29d. Date signed (Month, Day, Year) MAY 26, 1999										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANGELO LUCCO, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902																
31. Date filed (Month, Day, Year) MAY 28 1999				32. Registrar's Signature 												

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

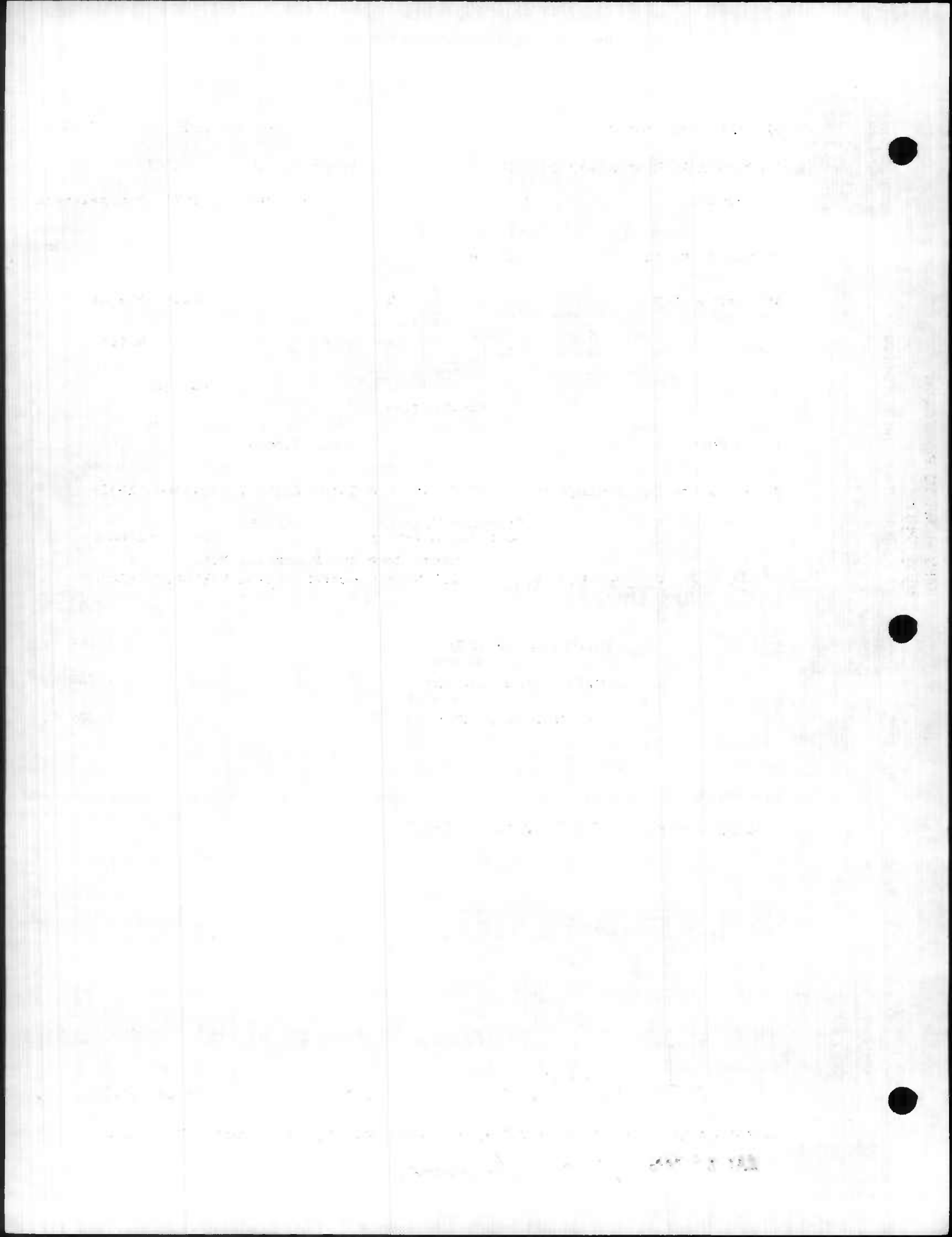
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6 + IVA

State
RegistrarNAME KNOWN TO PHYSICIAN:
NICK KAMIT

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18683

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NORA R. KING

2. Date of Death

Month Day Year MAY 25 1999

3. Time of Death

5:35 AM

4e. Facility Name (If not institution, give street and number)

DOCTORS COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

206-32-8298

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) November 11, 1942

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1229 Pickering Circle

10f. Zip Code

20774

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

4+

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Information Specialist

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Clifford Rhodes

18. Mother's Name (First, Middle, Maiden Surname)

Helen (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Warren H. King

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1229 Pickering Circle, Upper Marlboro, Maryland 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

06/04
1999

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Behna J. Jenkins

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William S. Rios

29c. License number

D29671

29d. Date signed (Month, Day, Year)

5/25/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

VILLAMOR S. RIOS, M.D. 6501 Landover Rd. Cheverly MD 20785

31. Date filed (Month, Day, Year)

MAY 27 1999

32. Registrar's Signature

B. Sparks

State
RegistrarNORA KING
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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2014 3 YOE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18684

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUSSELL EARL KENNEY				2. Date of Death Month Day Year May 19 1999		3. Time of Death 1013						
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO						
Funeral Director	5. Social Security Number 215-26-4743		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 3, 1929	9. Birthplace (State or Foreign Country) MARYLAND					
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10e. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location HEBRON		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	10e. Street and Number 502 S. MAIN ST.				10f. Zip Code 21830		10g. Citizen of What Country? U.S.A.						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: ARMY		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER		16b. Kind of Business/Industry SELF EMPLOYED								
	17. Father's Name (First, Middle, Last) ROBERT KENNEY				18. Mother's Name (First, Middle, Maiden Surname) MARY EDITH HIGNUTT								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) GERTRUDE L. KENNEY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 S. MAIN ST. HEBRON, MARYLAND 21830								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEBRON CEMETERY		Date 5/23/99		20c. Location - City or Town, State HEBRON, MARYLAND						
	21. Signature of Funeral Service Licensee Robert W. Harris Jr.		22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Ventricular Fibrillation</td> <td rowspan="4">Approximate Interval Between Onset and Death minutes hours</td> </tr> <tr> <td>b. Acute MI</td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Ventricular Fibrillation	Approximate Interval Between Onset and Death minutes hours	b. Acute MI	c.
Immediate Cause (Final disease or condition resulting in death)	a. Ventricular Fibrillation	Approximate Interval Between Onset and Death minutes hours											
	b. Acute MI												
	c.												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier Christy Huddleston				29c. License number D29105		29d. Date signed (Month, Day, Year) 5/20/99							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christy Huddleston, M.D. 106 MILFORD ST. SALISBURY, MD													
31. Date filed (Month, Day, Year) MAY 21 1999		32. Registrar's Signature B Sparks											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ced
2x14A

State
Registrar

1. The first part of the report is a general
description of the project.

2. The second part is a detailed description
of the methods used.

3. The third part is a description of the
results obtained.

4. The fourth part is a discussion of the
results and their significance.

5. The fifth part is a conclusion of the
project.

6. The sixth part is a list of references.

7. The seventh part is a list of
figures and tables.

8. The eighth part is a list of
appendices.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18685

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Harold John

Keyton

2. Date of Death

May 22 1999

Day Year

3. Time of Death

3:40

4a. Facility Name (If not Institution, give street and number)

Univ. of Maryland Medical System Baltimore

4b. City, Town, or Location of Death

4c. County of Death

Baltimore City

5. Social Security Number

212-20-5668

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 15, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

Maryland Prince George's

Forestville

10e. Street and Number

6507 Lacona Street

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1943-195413. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Insurance Agent

16b. Kind of Business/Industry

Metropolitan Life Ins. Co.

17. Father's Name (First, Middle, Last)

Samuel J. Keyton

18. Mother's Name (First, Middle, Maiden Surname)

Lillian P. Heim

19a. Informant's Name/Relationship (Type, Print)

Doris M. Keyton (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6507 Lacona Street Forestville, Maryland 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)May 27, 1999
Maryland State Veterans Cem.

Date

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Rd Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Multiple Strokes

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Cerebral Hemorrhage

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia

Diabetes

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

John W. Cole, MD

29c. License number

P12746

29d. Date signed (Month, Day, Year)

May 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Cole

22 South Greene St. BALTO, MD 21201

31. Date filed (Month, Day, Year)

MAY 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

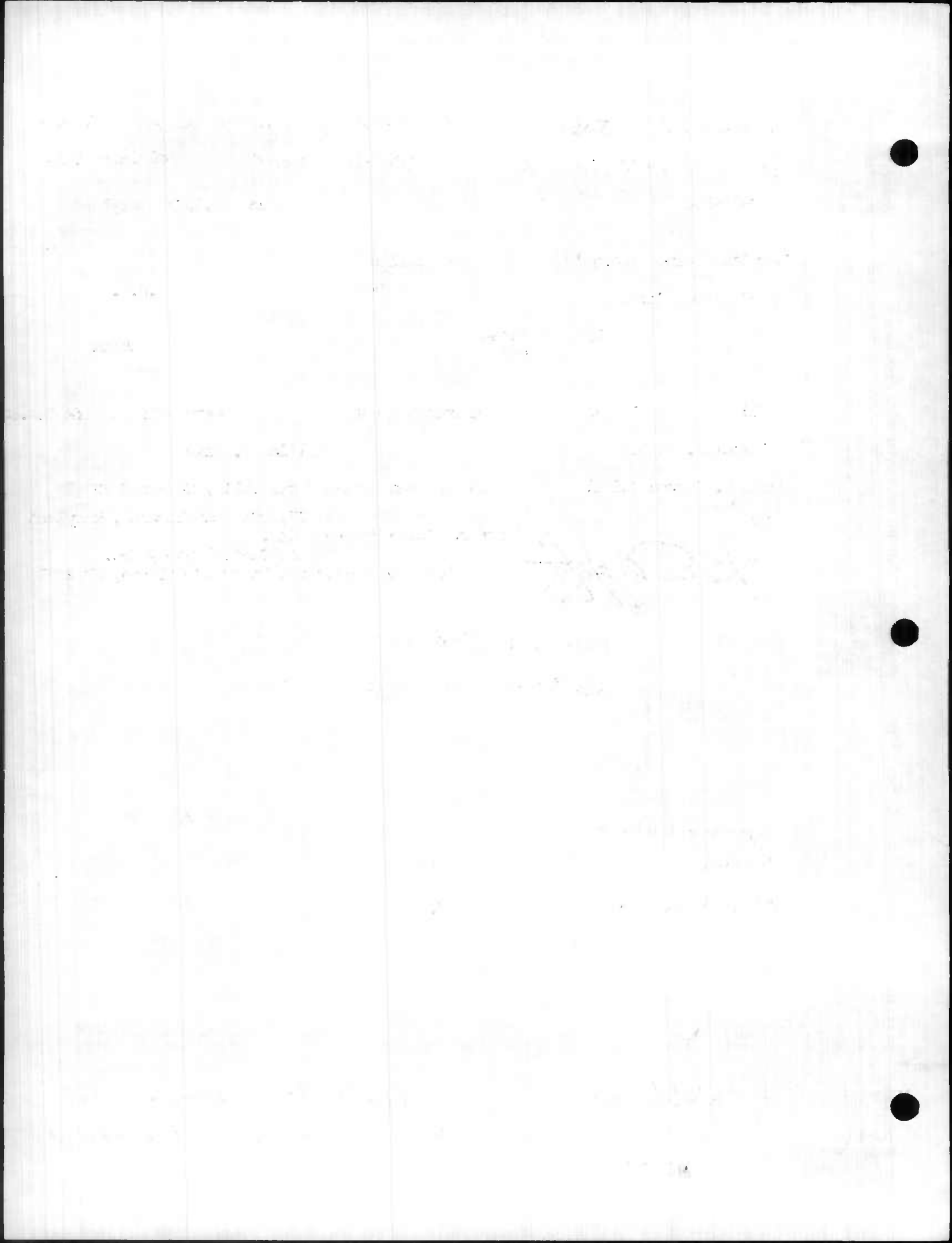
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

79 18686

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOMINGO LUGO				2. Date of Death Month Day Year MAY 18 1999		3. Time of Death 4:43 PM	
	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				4b. City, Town, or Location of Death TAKOMA PARK		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 581-22-7660		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) FEB 4, 1914	
	9. Birthplace (State or Foreign Country) PUERTO RICO		10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location HYATTSVILLE	
Usual Residence of Decedent								
10a. State MARYLAND			10b. County PRINCE GEORGES			10c. City, Town or Location HYATTSVILLE		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 2006 OLIVER STREET			10f. Zip Code 20782		
10g. Citizen of What Country? UNITED STATES			11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorcad			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: PUERTO RICAN			14. Race - American Indian, Black, White, etc. Specify: WHITE			15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collage (1-4or 5+) 12		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER			16b. Kind of Business/Industry SELF EMPLOYED			17. Father's Name (First, Middle, Last) AMADOR LUGO		
18. Mother's Name (First, Middle, Maiden Surname) JUANA MONTALVO			19a. Informant's Name/Relationship (Type, Print) MARTA LUGO (WIFE)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 OLIVER STREET, HYATTSVILLE MARYLAND 20782		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CEMETERY			20c. Location - City or Town, State BRENTWOOD, MARYLAND		
21. Signature of Funeral Service Licensee <i>Rosa Dutierrez</i> MO0907			22. Name and Address of Facility FORT LINCOLN FUNERAL HOME INC, 3401 BLADENSBURG RD, BRENTWOOD MARYLAND 20722					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 2 weeks								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of causa of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicida 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.								
29b. Signature and title of certifier <i>Michael S. ...</i>			29c. License number D21400			29d. Date signed (Month, Day, Year) May 19, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH G. H. 7610 Carroll Ave #280 Takoma Park Md. 20912								
31. Date (Month, Day, Year) MAY 24 1999			32. Registrar's Signature <i>...</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

22

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

18687

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen D. Luckey				2. Date of Death Month May Day 20 Year 1999				3. Time of Death 2:35PM		
	4a. Facility Name (If not Institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 217-24-9785		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) June 13, 1926		9. Birthplace (State or Foreign Country) Baltimore, MD		
	Usual Residence of Decedent				10a. State Maryland				10b. County Prince George's		10c. City, Town or Location Hyattsville
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 2501 Van Buren Street				10f. Zip Code 20782		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Twelve years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Analyst				16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) Samuel Johnson				18. Mother's Name (First, Middle, Maiden Surname) Mary Susan Berger							
19a. Informant's Name/Relationship (Type, Print) Mary E. Luckey - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Van Buren St. Hyattsville, MD 20782							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hills Cemetery				Date 5/27/99		20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd., N.E. Washington, D.C. 20019							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) respiratory failure Due to (or as a consequence of): stroke Due to (or as a consequence of): Hypertension Due to (or as a consequence of): atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pneumonia / diabetes coronary artery disease				Approximate Interval Between Onset and Death 2 days 10 days years years							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia / diabetes coronary artery disease				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D 39372		29d. Date signed (Month, Day, Year) May 20th 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 344 UNIVERSITY BLVD SUIT 324, SILVER SPRING MD 20901				31. Date filed (Month, Day, Year) MAY 25 1999				32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

~~SECRET~~

1. The purpose of this document is to provide a summary of the information received from the source regarding the activities of the group in the area of [redacted] and [redacted].

2. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

3. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

4. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

5. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

6. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

7. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

8. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

9. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

10. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

11. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

12. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 18688**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TOMMIE LEE					2. Date of Death Month Day Year May 21, 1999		3. Time of Death 6:20 AM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital					4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 249-26-0243		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 22, 1925		9. Birthplace (State or Foreign Country) Sumter, S.C.
	Usual Residence of Decedent								
10a. State D.C.			10b. County N/A		10c. City, Town or Location Washington			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 5200 North Capitol Street N.W. #3					10f. Zip Code 20011		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Collage (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Records Clerk			16b. Kind of Business/Industry D.C. General Hospital	
17. Father's Name (First, Middle, Last) Bogan Lee					18. Mother's Name (First, Middle, Maiden Surname) Lena Benjamin				
19a. Informant's Name/Relationship (Type, Print) Beatrice Bartley - Sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5200 No. Capitol St. N.W. #2, Wash DC 20011				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Data 5/27/99		20c. Location - City or Town, State Brentwood, MD		
21. Signature of Funeral Service Licensee J. P. Marshall					22. Name and Address of Facility Marshall's Funeral Home, Inc. 4308 Suitland Road, Suitland, Maryland 20746				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </div> <div style="width: 60%;"> a. CARDIOPULMONARY ARREST Due to (or as a consequence of): b. METASTATIC PROSTATE CARCINOMA Due to (or as a consequence of): c. SEPTICEMIA Due to (or as a consequence of): d. </div> </div>									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier J. P. Marshall MD			29c. License number D46529		29d. Date signed (Month, Day, Year) MAY 21 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTOR ONYIAKA 7325A HAROVER PARKWAY GREENBELT MARYLAND 20770									
31. Date filed (Month, Day, Year) MAY 24 1999			32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020
 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural," or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18689

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice S. Lewis				2. Date of Death Month Day Year May 19, 1999		3. Time of Death 3:26PM														
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Prince Georges														
Funeral Director	5. Social Security Number 578-60-7092		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 27, 1903	9. Birthplace (State or Foreign Country) Virginia													
	Usual Residence of Decedent				10a. State D.C.		10b. County Washington														
To Be Completed by Funeral Director	10a. State D.C.		10b. County Washington		10c. City, Town or Location Washington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
	10e. Street and Number 3522 South Dakota Avenue, N.E.		10f. Zip Code 20018		10g. Citizen of What Country? United States																
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Government																
	17. Father's Name (First, Middle, Last) Spottwood Mallory				18. Mother's Name (First, Middle, Maiden Surname) Victoria Queen Elizabeth Reeves																
	19a. Informant's Name/Relationship (Type, Print) Randall Graham/Godson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4020 Emerald Lane #1 Bowie, Maryland 20716																
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Park		Date 5/25/99		20c. Location - City or Town, State Suitland, MD.														
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill RD. Suitland, MD. 20746																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. CEREBROVASCULAR THROMBOSIS</td> <td>Approximate Interval Between Onset and Death 30 MIN.</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</td> <td>8 YEARS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. CEREBROVASCULAR THROMBOSIS	Approximate Interval Between Onset and Death 30 MIN.	Due to (or as a consequence of):		b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	8 YEARS	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.		d.
Immediate Cause (Final disease or condition resulting in death)	a. CEREBROVASCULAR THROMBOSIS	Approximate Interval Between Onset and Death 30 MIN.																			
	Due to (or as a consequence of):																				
	b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	8 YEARS																			
	Due to (or as a consequence of):																				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.																				
	d.																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA SEIZURE DISORDER						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown															
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>[Signature]</i>																			
		29c. License number DO 4899		29d. Date signed (Month, Day, Year) 5/19/99																	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS HAND MD 4203 QUEENSBURY RD. HYATTSVILLE MD 20781																					
31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature <i>[Signature]</i>																			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18690

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY LANGRALL

2. Date of Death

Month Day Year
5/19/1999

3. Time of Death

5:35 P.M.

4a. Facility Name (If not Institution, give street and number)

At Home-20902 Bivalve Road

4b. City, Town, or Location of Death

Bivalve

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

213-44-1065

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12/17/1897

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Wicomico

10c. City, Town or Location

Bivalve

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

20902 Bivalve Wharf Road

10f. Zip Code

21814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Larmore

18. Mother's Name (First, Middle, Maiden Surname)

Garnetta Dickerson

19a. Informant's Name/Relationship (Type, Print)

Ernestine Twilley, Daughter 20902 Bivalve Wharf Road, Bivalve, Md 21814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bivalve Cemetery

Date

5/22

20c. Location - City or Town, State

Bivalve. Md

21. Signature of Funeral Service Licensee

MOO-417

22. Name and Address of Facility

Messick Funeral Home, P.O. Box 61
Bivalve, Maryland 21814

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal Failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen H. Laffey MD

29c. License number

D20683

29d. Date signed (Month, Day, Year)

5/21/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STEPHEN H. LAFFEY MD, PO Box 121 NANTICOLE MD 21840

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

Diana S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

18115 YAM

99 18691

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Kenneth Wayne Laurie				2. DATE OF DEATH MONTH DAY YEAR May 27, 1999		3. TIME OF DEATH 10:00 A^M	
4. SOCIAL SECURITY NUMBER 215 46 0031		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 4, 1946	
8. FACILITY NAME (If not institution, give street and number) 7805 Westover Lane				9b. CITY, TOWN OR LOCATION OF DEATH Clinton		9c. COUNTY OF DEATH P.G.	
10a. STATE M.D.		10b. COUNTY P.G.		10c. CITY, TOWN OR LOCATION Clinton		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7805 Westover Lane				10f. ZIP CODE 20735		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES: Vietnam		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineering Assistant		16b. KIND OF BUSINESS/INDUSTRY Bell Atlantic			
17. FATHER'S NAME (First, Middle, Last) Charles Eugene Laurie				18. MOTHER'S NAME (First, Middle, Maiden Surname) Norma Fairall			
19a. INFORMANT'S NAME (Type/Print) Judy F. Laurie (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7805 Westover Lane, Clinton, Maryland 20735			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery June 1, 1999 Clinton, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles L. Belanger				22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lymphoma Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 1 Year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER D-17605		29d. DATE SIGNED (Month, Day, Year) 5/28/99	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HAIDAR MD CLINTON MD							
31. DATE FILED (Month, Day, Year) JUN 01 1999		32. REGISTRAR'S SIGNATURE [Signature]					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18692

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elton Leslie Legg Sr.				2. Date of Death Month Day Year May 10 1999				3. Time of Death 7:53P	
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton				4c. County of Death Talbot	
Funeral Director	5. Social Security Number 214-32-0075		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 16, 1933		9. Birthplace (State or Foreign Country) Chester, MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Queen Anne's		10c. City, Town or Location Chester				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 300 Dominion Road				10f. Zip Code 21619				10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) _____		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waterman				16b. Kind of Business/Industry Self			
	17. Father's Name (First, Middle, Last) Elton Coleman Legg				18. Mother's Name (First, Middle, Maiden Surname) Mabel Eloise Hollman					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Shirley Benton Legg - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Dominion road, Chester, MD 21619					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Stevensville Cemetery		20c. Date May 14, 1999		20d. Location - City or Town, State Stevensville, MD			
	21. Signature of Funeral Service Licensee <i>Chad M. H. H.</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619					
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 5 days	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute myocardial infarction Congestive heart failure Peripheral vascular disease								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Andrea Allen</i>		29c. License number D35284		29d. Date signed (Month, Day, Year) 5/14/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Allen, M.D., 219 S. Washington St., Easton, MD 21601										
31. Date filed (Month, Day, Year) MAY 13 1999		32. Registrar's Signature <i>B. B. B.</i>								

Elton Leslie Legg
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18693

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter Henry Miller					2. Date of Death Month Day Year May 21 1999		3. Time of Death 1:26 AM		
	4a. Facility Name (If not institution, give street and number) Baltimore Veteran's Hospital					4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 271-12-6312		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) March 15, 1925		9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent									
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 603 Truxton Road					10f. Zip Code 21401		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4 or 5+) 2					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired U.S. Army			16b. Kind of Business/Industry United States Government		
17. Father's Name (First, Middle, Last) Anthony Miller					18. Mother's Name (First, Middle, Maiden Surname) Myrtle Schneider					
19a. Informant's Name/Relationship (Type, Print) Carolyn Vandertie / daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Truxton Road, Annapolis, MD 21401					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		Date June 1 1999		20c. Location - City or Town, State Arlington, VA			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Ross Sugar, MD					29c. License number P09758		29d. Date signed (Month, Day, Year) May 21, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ross Sugar, M.D. 10 North Greene Street, Baltimore, MD 21201										
31. Date filed (Month, Day, Year) MAY 25 1999			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WRC
99-3043-003
MARK E.
McFADDEN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18694

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Mark E. McFadden		2. Date of Death Month MAY Day 26, Year 1999		3. Time of Death 3:00 PM.	
4a. Facility Name (If not institution, give street and number) BWI AIRPORT GATE D-8		4b. City, Town, or Location of Death Linthicum		4c. County of Death ANNE ARUNDEL	
5. Social Security Number 227-70-6084		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 46	
8. Date of Birth (Month, Day, Year) Dec. 11, 1952		9. Birthplace (State or Foreign Country) New York			
10a. State California		10b. County San Diego		10c. City, Town or Location San Diego	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3422 Winlow Street		10f. Zip Code 92105	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Graphic Artist		16b. Kind of Business/Industry Art	
17. Father's Name (First, Middle, Last) George L. McFadden		18. Mother's Name (First, Middle, Maiden Surname) Floretta Beasley			
19a. Informant's Name/Relationship (Type, Print) Cynthia Hamstra/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3422 Winlow Street San Diego, CA 92105			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 5-31-99 Alexandria, Virginia	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 10 Yes 20 No	
28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.	
29d. Date signed (Month, Day, Year) MAY 27, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRISON KOBORIN 111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) JUN 01 1999		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18695

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lawrence Mishner

2. Date of Death
Month Day Year
MAY 24, 19993. Time of Death
1327 PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

577-92-3196

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

24 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 10, 1975

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7301 Riggs Road

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Car Detailer

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Leroy Edelin

18. Mother's Name (First, Middle, Maiden Surname)

Edith I. Mishner

19a. Informant's Name/Relationship (Type, Print)

Edith I. Mishner - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1352 Fairmont St., N.W. #6 Washington, D.C. 20009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glenwood Cemetery

Date

6/1/99

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home, Inc.

4001 Benning Rd., N.E. Washington, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Multiple Gunshot Wound*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☒ Homicide

28a. Date of Injury (Month, Day, Year)

5/24/99

28b. Time of Injury

1240 PM

28c. Injury at Work?

1 ☒ Yes 2 ☐ No

28d. Describe how injury occurred

subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

building

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5728 Tuxedo Road Cheverly, Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis Chute M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

*Dennis Chute*Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18696

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lessie Peterson Manuel				2. Date of Death Month Day Year May 17, 1999		3. Time of Death 5:45 A.M.		
	4a. Facility Name (If not institution, give street and number) Heartland Healthcare Center				4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 577-58-4669		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) May 21, 1915		
	9. Birthplace (State or Foreign Country) South Carolina		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Hyattsville		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 6500 Riggs Road		10f. Zip Code 20783		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping		16b. Kind of Business/Industry Domestic			
17. Father's Name (First, Middle, Last) Sharp Peterson				18. Mother's Name (First, Middle, Maiden Surname) Annie Dubois					
19a. Informant's Name/Relationship (Type, Print) Mr. Levern Bacote (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3553 Jay Street, N.E. Washington, D.C. 20019					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery		Date 5/21/99		20c. Location - City or Town, State Washington, D.C.			
21. Signature of Funeral Service Licensee <i>Paul A. Devore</i>				22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Carcinoma Colon Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia, End Stage Dysphagia								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Paul A. Devore</i>				29c. License number D01852		29d. Date signed (Month, Day, Year) May 25 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. Devore, MD 4203 Queensbury Road Hyattsville, Maryland 20781									
31. Date filed (Month, Day, Year) MAY 26 1999		32. Registrar's Signature <i>B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Handwritten signature and date: 1001 8 5 1941

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18697

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Camille Mitchell</i>			2. Date of Death Month <i>MAY</i> Day <i>22</i> Year <i>1999</i>			3. Time of Death <i>3:55 PM</i>				
	4a. Facility Name (If not institution, give street and number) <i>Shady Grove Adventist Hospital</i>			4b. City, Town, or Location of Death <i>Rockville, MD</i>			4c. County of Death <i>Montgomery</i>				
Funeral Director	5. Social Security Number <i>221-46-9548</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>42</i> Yrs.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country) <i>NORTH CAROLINA</i>		
	Usual Residence of Decedent			10a. State <i>MD.</i>		10b. County <i>MONTGOMERY</i>		10c. City, Town or Location <i>ROCKVILLE</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>522 LONGWOOD DRIVE</i>			10f. Zip Code <i>80250</i>			10g. Citizen of What Country? <i>U.S.A.</i>					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>4</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>IMPORT EXPORT LICENSING DET</i>			16b. Kind of Business/Industry <i>U.S. GOVERNMENT</i>					
17. Father's Name (First, Middle, Last) <i>HERBERT W. MITCHELL</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>ELLEN ALSTON</i>								
19a. Informant's Name/Relationship (Type, Print) <i>LARRY C. MITCHELL</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>705 MEADOWBROOK DRIVE LIMA OHIO 45801</i>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>SILVERBROOK CEMETERY</i>			20c. Location - City or Town, State <i>WILM. DELAWARE</i>					
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <i>GEE FUNERAL HOME 259 E. MAIN ST ELKTON MD</i>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Respiratory Failure</i> Due to (or as a consequence of): <i>b. Cardiac Failure</i> Due to (or as a consequence of): <i>c. Metastatic Breast Cancer</i> Due to (or as a consequence of): <i>d. Cardiac Compromise</i>						Approximate Interval Between Onset and Death <i>14 days</i> <i>30 days</i> <i>4 years</i> <i>14 days</i>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>HUNG-CHUNG LEE</i>			29c. License number <i>D0045176</i>			29d. Date signed (Month, Day, Year) <i>MAY 22, 1999</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>HUNG-CHUNG LEE. 1396 PEECARD DR. ROCKVILLE, MD 20850</i>											
31. Date filed (Month, Day, Year) <i>MAY 27 1999</i>			32. Registrar's Signature <i>[Signature]</i>								

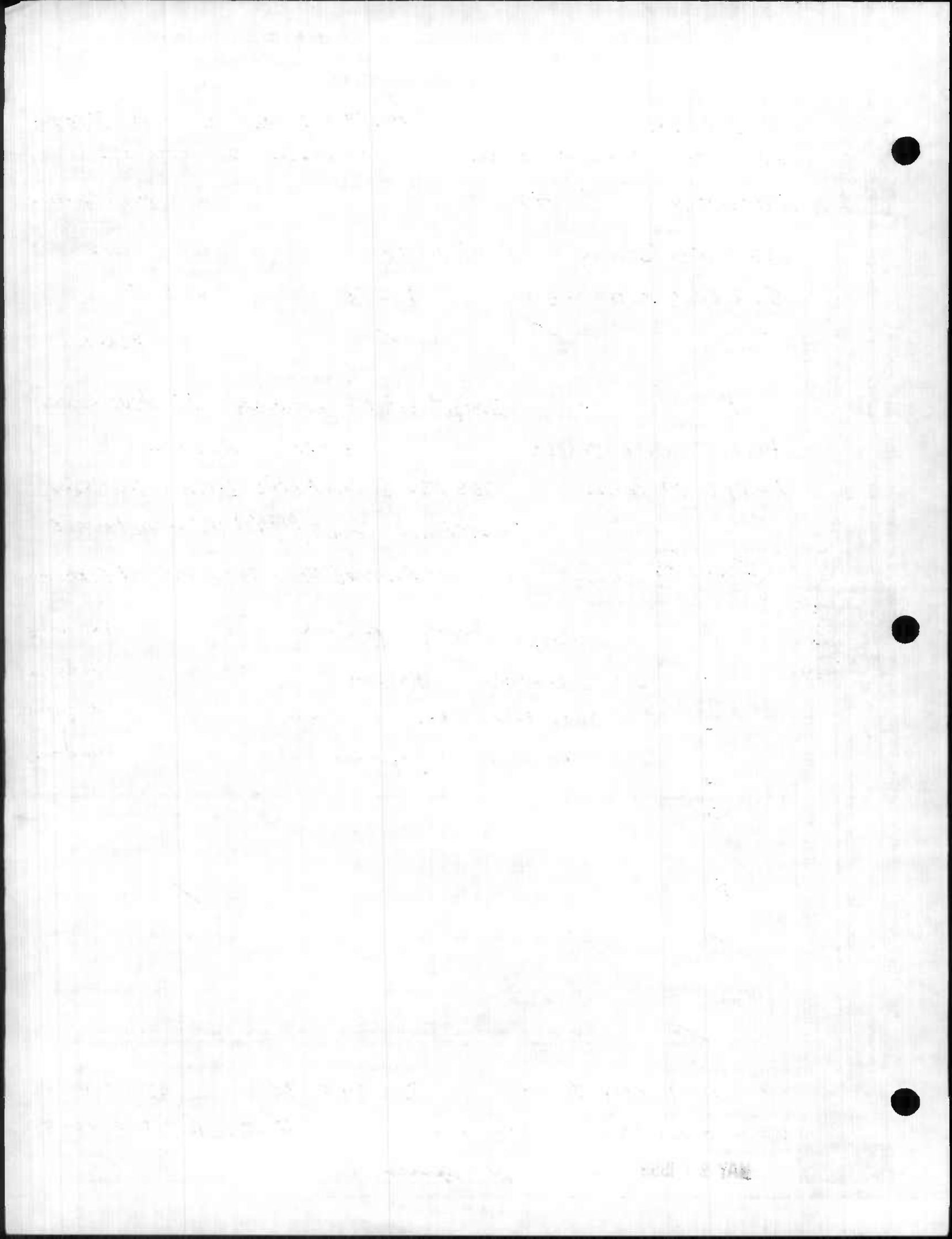
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18698

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edmund Randolph McCollin

2. Date of Death

May 26, 1999

3. Time of Death

6:25am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

128-28-0391

6. Sex

M 2 F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 28, 1936

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

4307 Knowles Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Ordained Minister

16b. Kind of Business/Industry

Ministry

17. Father's Name (First, Middle, Last)

Evans McCollin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Louise Haywood

19a. Informant's Name/Relationship (Type, Print)

Angela McCollin/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4307 Knowles Ave. Kensington, Md 20895

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory 5/27/99 Alexandria, Va

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Philip D. Rinaldi

22. Name and Address of Facility

PHILIP D. RINALDI FUNERAL SERVICE
11818 New Hampshire Ave. Silver Spg. Md23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Hepatocellular Carcinoma
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

60 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?
1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation
6 Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 Yes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Philip D. Rinaldi MD

29c. License number

D 53864

29d. Date signed (Month, Day, Year)

5/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard A. Silva 18101 Prince Phillip Dr. Olney, MD 20832

State
Registrar

31. Date filed (Month, Day, Year)

MAY 27 1999

32. Registrar's Signature

Barbara B. Sparks

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten signature or initials.

MAY 2 1959

①

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18699

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARTHA CRAWFORD MABRY				2. Date of Death Month 05 Day 24 Year 99				3. Time of Death 12:10 am		
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY				4c. County of Death PRINCE GEORGE'S		
Funeral Director	5. Social Security Number 578-48-6214		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) August 23, 1939		9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent				10. City, Town or Location Landover		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Landover		10e. Street and Number 1918 Palmer Park Road		10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) Harry Grayson						18. Mother's Name (First, Middle, Maiden Surname) Mary Frances Robinson					
19a. Informant's Name/Relationship (Type, Print) Jackie C. Browning/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14821 22nd East, Takoma, Washington 98445					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 05/28 1999		20c. Location - City or Town, State Beltsville, Maryland			
21. Signature of Funeral Service Licensee Nancy A. Perantoni						22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure 7 yrs Dilated Cardiomyopathy 7 yrs Ischemic Cardiomyopathy 7 yrs Myocardial Infarctions 7 yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NON INSULIN DEPENDENT DIABETES RESTRICTIVE LUNG DISEASE										23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier David A. Gooray MD.				29c. License number D 28195		29d. Date signed (Month, Day, Year) 5-24-99	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID A. GOORAY, MD. 12164 CENTRAL AVE. MITCHELLVILLE, MD. 20721											
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature Beynon B. Spauls							

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18700

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jean cameron Mathers

2. Date of Death

Month Day Year MAY 20 1999

3. Time of Death

3:50 P.M.

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

577-48-9883

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Feb 18, 1912

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

MD.

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1666 Carlyle Drive

10f. Zip Code

21114

10g. Citizen of What Country?

Great Britain

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Christina Cameron

19a. Informant's Name/Relationship (Type, Print)

John Mathers/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1032 Christmas La. Gambrills, Md. 21054

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln

Cemetery

Date

05-24-99

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

Shannon W. Ramirez
Shannon W. Ramirez M00798

22. Name and Address of Facility

Beall Funeral Home

6512 N.W. Crain Highway Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43977

29d. Date signed (Month, Day, Year)

May 20 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anken Okechiji. 301 Hanger Ave, Glen Burnie, MD. 21061.

31. Date filed (Month, Day, Year)

MAY 24 1999

32. Registrar's Signature

B. S. Smith

State
Registrar

JEAN MATHERS

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

8

10.1.28 720 10.1.28 720



Jorg Eugene Magruder

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MFO G772 6-14-99 WR. Items: 17, 18 per F.H.G-772 5/15/99 reb

Certificate of Death

Reg. No.

99 18701

Physician
/Medical
Examiner

Jorg Eugene Magruder

2. Date of Death
Month Day Year
June 01, 1999
3. Time of Death
9:05 A.M.Funeral
Director

4a. Facility Name (If not institution, give street and number)

Route 450 Ramp to Balto.-Washington Pkwy.

4b. City, Town, or Location of Death

Bladensburg

4c. County of Death

Prince George's

5. Social Security Number

218-96-0520

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

34 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 24 1965

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3722 Ingalls Ave.

10f. Zip Code

20784

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

LEWIS HENRY MAGRUDER

18. Mother's Name (First, Middle, Maiden Surname)

INGEBORG MARIA KRAUS
~~Ingaborg Kraus~~

19a. Informant's Name/Relationship (Type, Print)

Annette Magruder - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3722 Ingalls Ave., Landover, MD 20784

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resurrection Cemetery

Date

6/7/99

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☒ Yes ☐ No25. Was case referred to medical
examiner?
☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) at scene

27. Manner of Death

☐ Natural ☐ Pending
Investigation
☐ Accident ☒ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)
Found:
6-1-99

28b. Time of

Injury
Found:
8:55

28c. Injury at

Work?
☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

FOUND IN PARK

28d. Describe how injury occurred

SUBJECT INGESTED DRUGS

28f. Location (Street and Number or Rural Route Number,
City or Town, State) RT. 450 RAMP TO BW

PRINCE GEORGE'S COUNTY, MD.

29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 02, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUN 04 1999

32. Registrar's Signature

B. B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18702

Miller, Geraldine M. 6540 W.P. 220-30-6820 3/30/99 5/25/99 20824

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Geraldine M. Miller</u>				2. Date of Death Month <u>5</u> Day <u>25</u> Year <u>99</u>		3. Time of Death <u>0824 AM</u>				
	4a. Facility Name (If not institution, give street and number) <u>Atlantic General Hospital</u>				4b. City, Town, or Location of Death <u>Berlin</u>		4c. County of Death <u>Worcester</u>				
Funeral Director	5. Social Security Number <u>220-30-6820</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>65</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>MAR. 30, 1934</u>	9. Birthplace (State or Foreign Country) <u>MARYLAND</u>			
	Usual Residence of Decedent										
10a. State <u>DELAWARE</u>		10b. County <u>SUSSEX</u>		10c. City, Town or Location <u>SELBYVILLE</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <u>90D CANVAS BACK ROAD, SWANN KEYS</u>				10f. Zip Code <u>19975</u>		10g. Citizen of What Country? <u>USA</u>					
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>CUSTOMER SERVICE REP.</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>BANKING</u>			16b. Kind of Business/Industry				
17. Father's Name (First, Middle, Last) <u>GEORGE MALESKI</u>				18. Mother's Name (First, Middle, Maiden Summa) <u>LAURA LAUFERT</u>							
19a. Informant's Name/Relationship (Type, Print) <u>VINCENT JAMES GENCO III/SON</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5105 MEADOWVIEW DRIVE, WHITEHALL, MARYLAND 21161</u>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>GARDENS OF FAITH</u>		Date <u>5/29/99</u>		20c. Location - City or Town, State <u>ROSEDALE, MARYLAND</u>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975</u>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.											
<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td style="width: 60%;"> a. <u>Intraabdominal Sepsis</u> Due to (or as a consequence of): b. <u>Renal Failure</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ </td> <td style="width: 10%; text-align: center; vertical-align: top;"> Approximate Interval Between Onset and Death <u>5 Days</u> <u>5 Days</u> </td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <u>Intraabdominal Sepsis</u> Due to (or as a consequence of): b. <u>Renal Failure</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____	Approximate Interval Between Onset and Death <u>5 Days</u> <u>5 Days</u>
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <u>Intraabdominal Sepsis</u> Due to (or as a consequence of): b. <u>Renal Failure</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____	Approximate Interval Between Onset and Death <u>5 Days</u> <u>5 Days</u>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
			28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier  Physician				29c. License number <u>H44283</u>		29d. Date signed (Month, Day, Year) <u>5/25/99</u>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Robert J. Duxkin DO 9733 Healthway Dr Berlin MD 21811</u>											
31. Date filed (Month, Day, Year) <u>MAY 26 1999</u>			32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18703

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph Lee Melvin, Jr.

2. Date of Death

Month
MAY

Day

18

Year

1999

3. Time of Death

0420

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

218-70-3934

6. Sex

M 20 F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 11, 1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

104 Whitmore Avenue

10f. Zip Code

21921

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Navar Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NA--Unable to work

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

Ralph Lee Melvin, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Linda Cole

19a. Informant's Name/Relationship (Type, Print)

Mrs. Donna Dukes (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

220 Conquest Rd., Centreville, Md. 21617

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Center

Date

May 21, 1999

20c. Location - City or Town, State

Stevensville, Md.

21. Signature of Funeral Service Licensee

Chel N. Hefner

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home

408 S. Liberty St., Centreville, Md. 21617

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Approximate Interval Between Onset and Death

Day

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital: 10 Inpatient 20 Outpatient 30 DOA

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending Investigation
20 Accident 60 Could not be determined
30 Suicide
40 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sachdev M.D.

29c. License number

D23322

29d. Date signed (Month, Day, Year)

5.20.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.S. SACHDEV M.D. 118 North 8 Suite 3B, Elkton MD 21921

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

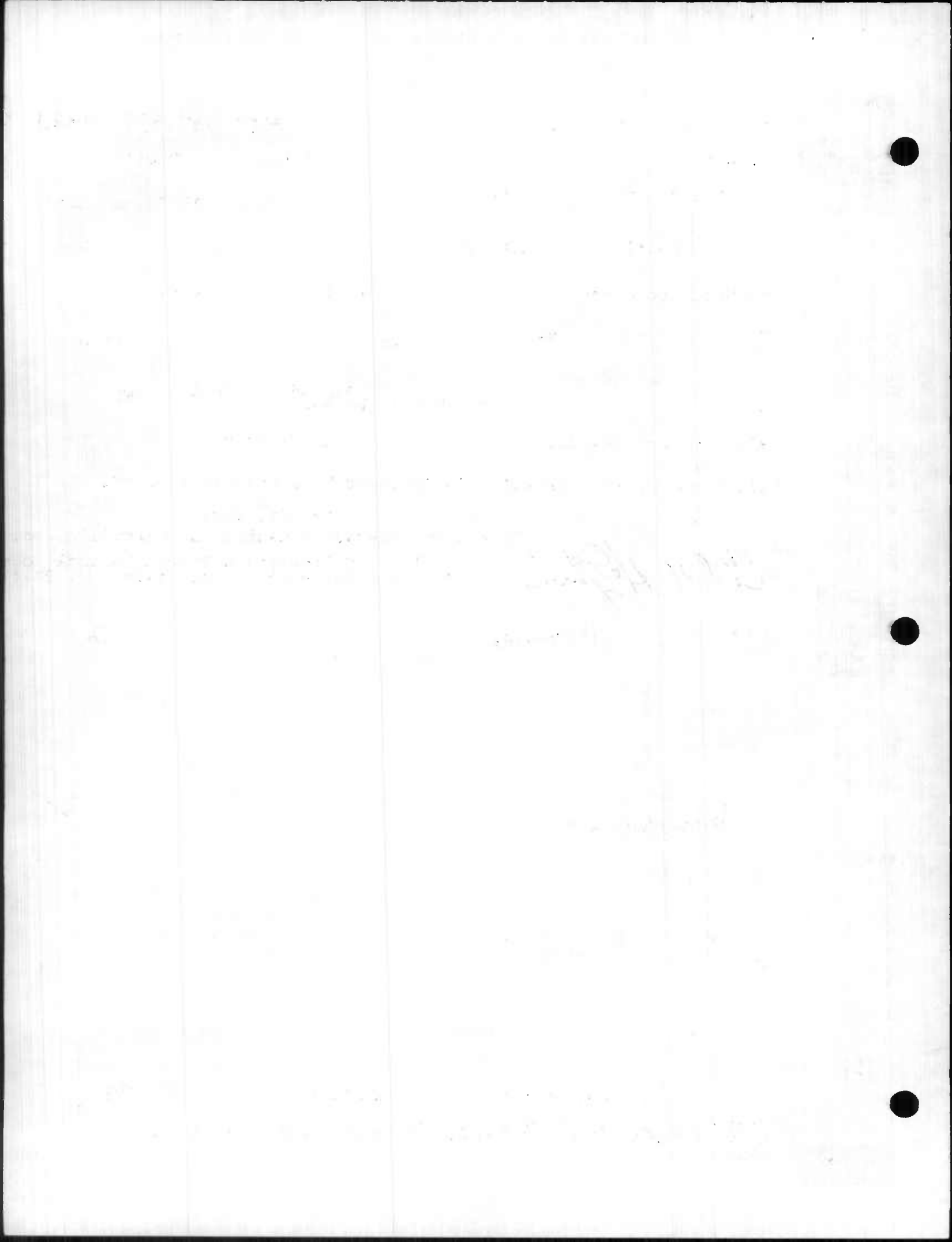
Medical Certification: To Be Completed by Physician/Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18704

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS NARCE JR				2. Date of Death Month 05 - Day 22 - Year 1999		3. Time of Death 8:50 AM		
	4a. Facility Name (If not institution, give street and number) Heartland Health Care of Hyattsville				4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 577-76-6251		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 30, 1953	9. Birthplace (State or Foreign Country) Wash., D.C.	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1736 Hobart St., N.W.				10f. Zip Code 20009		10g. Citizen of What Country? United States		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health Care Provider		16b. Kind of Business/Industry Private				
	17. Father's Name (First, Middle, Last) Thomas L. Narce, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Argine Crawford				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Clorethia R. Narce - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6357 Wingate St., Alexandria, VA 22312				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cem.		Date 6/1/99		20c. Location - City or Town, State Suitland, MD		
	21. Signature of Funeral Service Licensee John T. Stewart III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIO RESPIRATORY FAILURE				Approximate Interval Between Onset and Death				
	Due to (or as a consequence of): AIDS								
Due to (or as a consequence of): GROSSEPSIS									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury NA M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred NA	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NA				28f. Location (Street and Number or Rural Route Number, City or Town, State) NA			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier MD							
		29c. License number D42919		29d. Date signed (Month, Day, Year) 05-26-1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS NARCE JR		31. Date filed (Month, Day, Year) MAY 27 1999							
		32. Registrar's Signature B. Spence							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

(5)

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

JUN 2 1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18705

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN NIELSEN				2. Date of Death Month May Day 24 Year 1999		3. Time of Death 2225																								
	4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent																								
Funeral Director	5. Social Security Number 063-12-9673		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) July 16 1920																								
	9. Birthplace (State or Foreign Country) New York		10a. State MD		10b. County Kent		10c. City, Town or Location Kennedyville																								
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 29150 Ricks Landing Rd.		10f. Zip Code 21645																									
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1942 If Yes, Give Year or Dates: -1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:																									
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Builder		16b. Kind of Business/Industry Commerical & Residential Const.																									
17. Father's Name (First, Middle, Last) Jens Christian Nielsen				18. Mother's Name (First, Middle, Maiden Surname) Kirsten Jensen																											
19a. Informant's Name/Relationship (Type, Print) Margaret Nielsen (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21645 29150 Ricks Landing Rd. Kennedyville, MD.																											
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory		20c. Location - City or Town, State 5/26/99 Dover, DE.		20d. Date																									
21. Signature of Funeral Service Licensee  MO0510		22. Name and Address of Facility Galena Funeral Home of Stephen Schaech 118 W. Cross St. Galena, MD. 21635																													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																															
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Cardiac arrest</td> <td>1 minute</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Pulmonary arrest</td> <td>2 days</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td>cerebrovascular accident, hemorrhage</td> <td>2 days</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>myocardial infarction</td> <td>3 days</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	Cardiac arrest	1 minute	Due to (or as a consequence of):			b.	Pulmonary arrest	2 days	Due to (or as a consequence of):			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	cerebrovascular accident, hemorrhage	2 days	Due to (or as a consequence of):			d.	myocardial infarction	3 days	
Immediate Cause (Final disease or condition resulting in death)	a.	Cardiac arrest	1 minute																												
	Due to (or as a consequence of):																														
	b.	Pulmonary arrest	2 days																												
	Due to (or as a consequence of):																														
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	cerebrovascular accident, hemorrhage	2 days																												
	Due to (or as a consequence of):																														
d.	myocardial infarction	3 days																													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTN Hypercholesterolemia						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No																									
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																											
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																											
29b. Signature and title of certifier 		29c. License number D51735		29d. Date signed (Month, Day, Year) 5/31/99																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Delboy MD Round Top Medical Center Chestertown, MD. 21620																															
31. Date filed (Month, Day, Year) JUN 01 1999		32. Registrar's Signature 																													

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

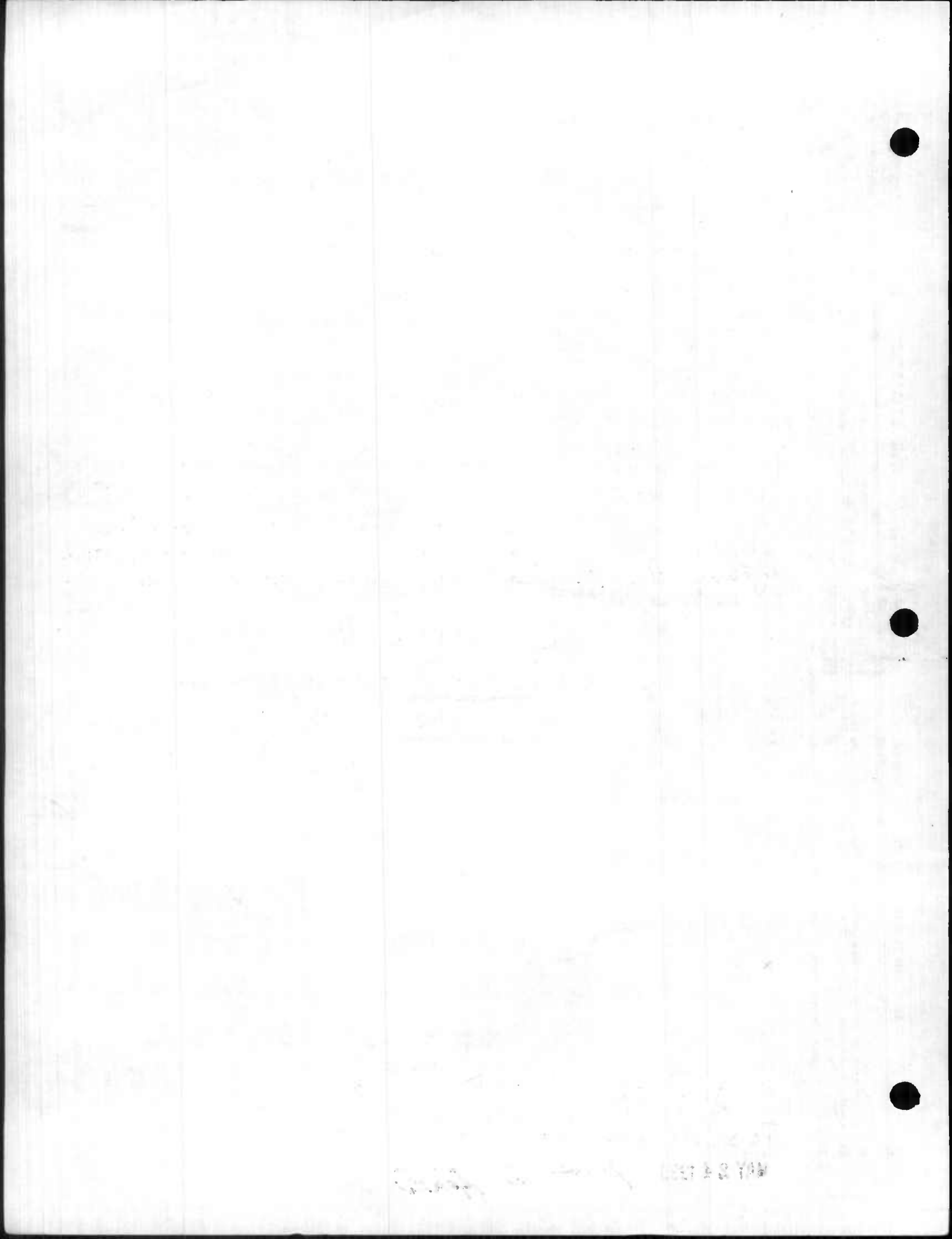
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18706

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAME KHOUDIA NIANG				2. Date of Death Month Day Year MAY 19, 1999				3. Time of Death 1920 PM	
	4a. Facility Name (If not institution, give street and number) DOCTOR'S COMMUNITY HOSPITAL				4b. City, Town, or Location of Death LANHAM				4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 577-17-9063		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) 9-14-55		9. Birthplace (State or Foreign Country) SENEGAL	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 81 University Blvd				10f. Zip Code 20901		10g. Citizen of What Country? Senegal			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse				16b. Kind of Business/Industry Private Duty	
	17. Father's Name (First, Middle, Last) Ibrahima Niang				18. Mother's Name (First, Middle, Maiden Surname) Awa Diop					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Tidjani Niang- Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6483 Brickheart Ct, Alexandria, Va. 22306					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Family Cemetery		20c. Date 5-28-99		20d. Location - City or Town, State Dakar, Senegal			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Universal Mortuary Inc. 411 Kennedy St., N.W., Wash., D.C.					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebral Hemorrhage Due to (or as a consequence of): Ruptured aneurysm in Association with Hypertensive Cardiovascular Disease									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i> M.D.				29c. License number O.C.M.E	
	29d. Date signed (Month, Day, Year) MAY 21, 1999									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestano 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature <i>[Signature]</i>								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18707

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Aiden Kenneth Nikkel				2. Date of Death Month: MAY Day: 25 Year: 1999		3. Time of Death 20:30	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
Funeral Director	5. Social Security Number N/A		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year MAY 23, 1999	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Harwood			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 4776 B Carmody Court				10f. Zip Code 20776		10g. Citizen of What Country? United States		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A Collage (1-4or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A			16b. Kind of Business/Industry N/A	
17. Father's Name (First, Middle, Last) Ryan Kenneth Nikkel				18. Mother's Name (First, Middle, Maiden Surname) Rosemary Marie Manson				
19a. Informant's Name/Relationship (Type, Print) Ryan Nikkel (FATHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4776 B Carmody Court, Harwood, Maryland 20776				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory May 28, 1999		20c. Location - City or Town, State Clinton, Maryland		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) Persistent Pulmonary Hypertension								8 hours
Due to (or as a consequence of): Multiple Congenital Anomalies.								8 hours
Due to (or as a consequence of): Tetralogy of Fallot.								8 hours
Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier A. E. Del-III			29c. License number D-0052933		29d. Date signed (Month, Day, Year) May 25th 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALSTON E. DUNBAR III 600 North Wolfe Street, Baltimore, Maryland 21287								
31. Date filed (Month, Day, Year) JUN 01 1999		32. Registrar's Signature Benita B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18708

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymon G. Phipps				2. Date of Death Month Day Year May 28 1999		3. Time of Death 11:34 PM										
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel										
Funeral Director	5. Social Security Number 217-16-4312		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 9, 1923										
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis										
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 135 Porter Drive		10f. Zip Code 21401		10g. Citizen of What Country? USA											
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Logistics Specialist		16b. Kind of Business/Industry U.S. Civil Service													
17. Father's Name (First, Middle, Last) Raymond Phipps				18. Mother's Name (First, Middle, Maiden Surname) Anna Meriken													
19a. Informant's Name/Relationship (Type, Print) Robin P. Whray / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Shamrock Dr. Summerville, S.C. 29483													
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery		20c. Location - City or Town, State Annapolis, Maryland		20d. Date 6-2-99											
21. Signature of Funeral Service Licensee C. Brian Powell				22. Name and Address of Facility 147 Duke of Gloucester St. John M. Taylor FH, Inc. Annapolis, Maryland 21401													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Multiple Organ Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death acute chronic chronic</td> </tr> <tr> <td>b.</td> <td>Chronic Renal Failure</td> </tr> <tr> <td>c.</td> <td>Hypertension</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Multiple Organ Failure	Approximate Interval Between Onset and Death acute chronic chronic	b.	Chronic Renal Failure	c.	Hypertension	d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Multiple Organ Failure	Approximate Interval Between Onset and Death acute chronic chronic														
	b.	Chronic Renal Failure															
	c.	Hypertension															
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary Disease Cor pulmonale																	
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier R. Bokhari MD		29c. License number D-26594		29d. Date signed (Month, Day, Year) 5/28/99											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) R. Bokhari M.D. Anne Arundel Medical Center, Annapolis MD 21401																	
31. Date filed (Month, Day, Year) JUN 01 1999		32. Registrar's Signature B. Sparks															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

James J. [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18709

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anne Margaret Poist					2. Date of Death Month Day Year May 20, 1999		3. Time of Death 8:30 pm	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center					4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 213-14-2967		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 27, 1919		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent								
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severna Park			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 504 Retford Drive				10f. Zip Code 21146		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Joseph Watts					18. Mother's Name (First, Middle, Maiden Surname) Margaret Schindhelm				
19a. Informant's Name/Relationship (Type, Print) Liguori Tewes/Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Retford Drive Severna Park, MD 21146				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cem.		Date May 24 1999		20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Barranco & Sons Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CVA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and Title of certifier 					29c. License number 041816		29d. Date signed (Month, Day, Year) 5/20/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Phelps MD Anne Arundel Medical Center 64 Franklin St. Annapolis, MD 21401									
31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18710

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

HERBERT

ELZIA

PARKER

2. Date of Death
Month Day Year
5/20/993. Time of Death
9:03 AM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES COUNTY MEDICAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PG

5. Social Security Number

577-88-5252

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

36

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

8/14/1962

9. Birthplace (State or Foreign Country)

CHEVERLY

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

FAIRMONT HEIGHTS

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1013 58TH AVENUE

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

SINGLE

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4or 5+)

NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COMPUTER OPERATOR

16b. Kind of Business/Industry

OFFICE WORKER

17. Father's Name (First, Middle, Last)

WILLIAM PARKER

18. Mother's Name (First, Middle, Maiden Surname)

CECIL TAYLOR

19a. Informant's Name/Relationship (Type, Print)

CECIL T. PARKER (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS 10A,B,C,D,E,&F

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEM PK CEM

Date

5/25/99

20c. Location - City or Town, State

LANDOVER, MD.

21. Signature of Funeral Service Licensee

Juan Smith

22. Name and Address of Facility

JOHN T. RHINES CO., INC.

3030 12TH ST NE, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Pneumonia*

Due to (or as a consequence of):

b. *Possible pulmonary tuberculosis*

Due to (or as a consequence of):

c. *Possible pneumocystic carinii pneumonia*

Due to (or as a consequence of):

d. *Acquired immune deficiency Syndrome*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Wasting syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Mohamed, MD

29c. License number

00053680

29d. Date signed (Month, Day, Year)

5/20/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Qaisra Saeed, Dept of Internal Med
Prince George's Hosp, 3001 Hospital Drive, Cheverly, MD 20785

31. Date filed (Month, Day, Year)

MAY 24 1999

32. Registrar's Signature

*Barbara A. Apaisi*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18711

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VERA B. POTTER

2. Date of Death

May 22, 1999

3. Time of Death

4:00 p.m.

4a. Facility Name (If not institution, give street and number)

ST MARYS NURSING HOME

4b. City, Town, or Location of Death

LEONARDTOWN

4c. County of Death

ST MARYS

Funeral
Director

5. Social Security Number

513-07-9002

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 18, 1921

9. Birthplace (State or Foreign Country)

KANSAS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ST MARYS

10c. City, Town or Location

CHARLOTTE HALL

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

30155 GERSHWIN ROAD

10f. Zip Code

20622

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

DEPT OF AGRICULTURE

17. Father's Name (First, Middle, Last)

THOMAS LOVELL BRADLEY

18. Mother's Name (First, Middle, Maiden Surname)

NELL C. JONES

19a. Informant's Name/Relationship (Type, Print)

CARL POTTER (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

48137 CHRISTIAN WAY, LEXINGTON PK MARYLAND 20653

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

5-27-99

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

Raisa Dittmer MO0907

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME INC.

3401 BLADENSBURG RD, BRENTWOOD MARYLAND 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Circulator collapse

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiac arrhythmia

Due to (or as a consequence of):

4 hrs

c. Leukemia

Due to (or as a consequence of):

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Leon W. Brubaker MD

29c. License number

D00506

29d. Date signed (Month, Day, Year)

MAY 24, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

28170 OLD VILLAGE ROAD, MECHANICSVILLE MARYLAND 20659

31. Date filed (Month, Day, Year)

MAY 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Decedent: Vera Potter

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18712

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Beatrice Pratt				2. Date of Death Month May Day 23 Year 1999		3. Time of Death 9:58 AM	
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 240-40-2984		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 03, 1924	9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Laurel			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 9573 Muirkirk Road				10f. Zip Code 20708		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aide			16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Roe McNeill				18. Mother's Name (First, Middle, Maiden Surname) Victoria Patterson				
19a. Informant's Name/Relationship (Type, Print) Ronald Jones/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 South Stephens Street, South Pines, North Carolina 28387				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Pinelawn Cemetery		Date 05/29 1999		20c. Location - City or Town, State Southern Pines, N.C.
21. Signature of Funeral Service Licensee Nancy A. Perce				22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebrovascular Accident Due to (or as a consequence of): Embolus Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 11 days.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiomyopathy.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier [Signature]				
29c. License number 024283				29d. Date signed (Month, Day, Year) 5.23.99				
30. Name and address of person who completed cause of death (Item 29a) (Type, Print) M. YUSUF MD 13631 Baltimore Ave. Laurel, MD 20707								
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Handwritten signature or initials

2001 3 3 YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18713

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Corleise Anita Penn

2. Date of Death

Month Day Year
May 21, 1999

3. Time of Death

11:40 am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-32-6638

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 2, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5721 Grosvenor Lane

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Medical Industry

17. Father's Name (First, Middle, Last)

Spencer M. Penn

18. Mother's Name (First, Middle, Maiden Surname)

(Unavailable)

19a. Informant's Name/Relationship (Type, Print)

Bonnie Stein - Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

102 Annapolis View Road, Stevensville, MD 21666

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

05/26/99

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *sepsis*
Due to (or as a consequence of):

b. *pneumonia*
Due to (or as a consequence of):

c. *aspiration*
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

urinary tract infection
dementia
tardive dyskinesia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Elliot R. Goldstein M.D.

DD 3581

May 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elliot R. Goldstein, M.D. 9410 Old Georgetown Road, Bethesda, Maryland 20814-1700

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

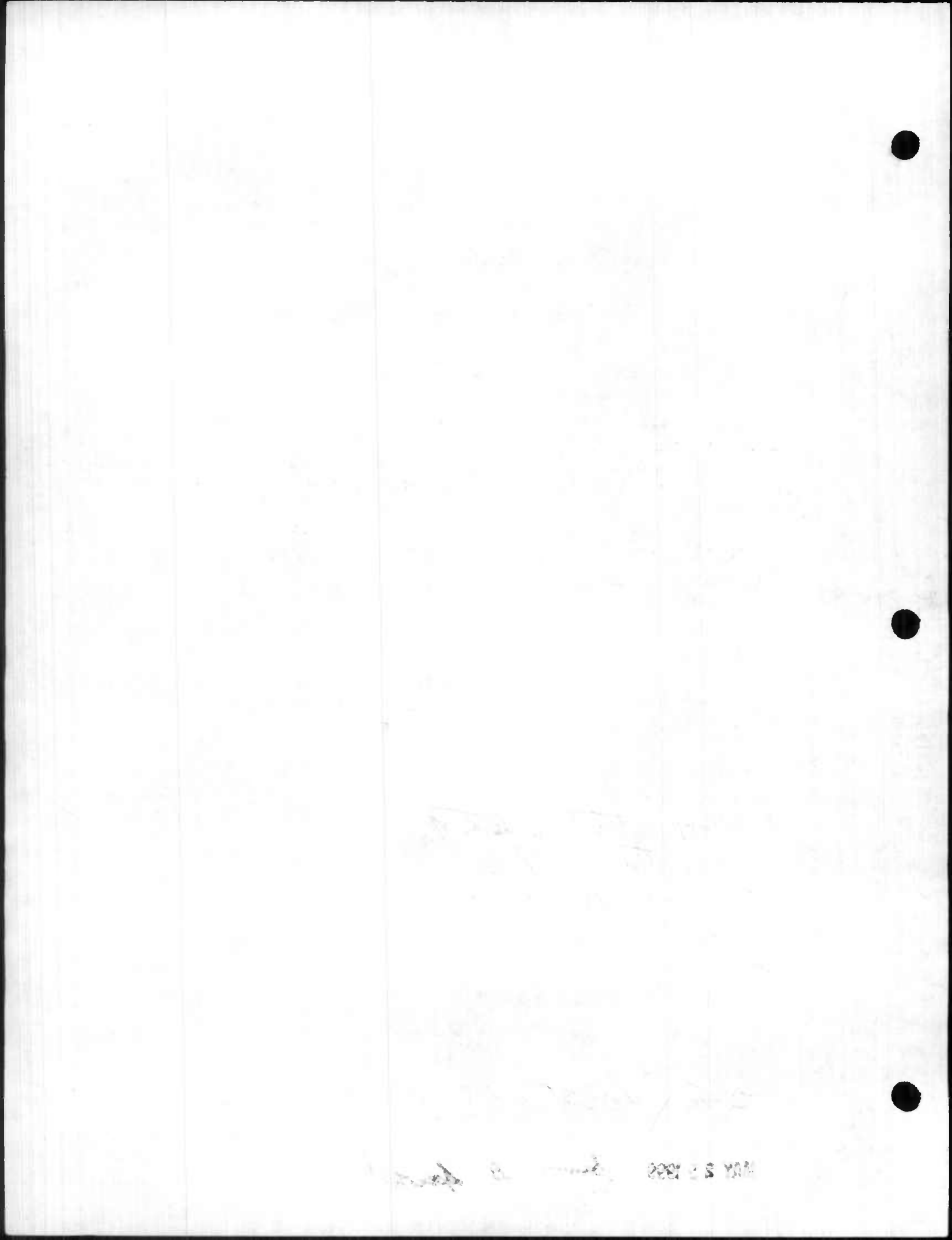
B. Jones

State Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Physician
/Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1. Decedent's Name (First, Middle, Last) John K. Pinkney		2. Date of Death Month MAY Day 25 Year 1999		3. Time of Death 1029 P	
4a. Facility Name (If not institution, give street and number) 3375 MALCOLM ROAD		4b. City, Town, or Location of Death BRANDYWINE		4c. County of Death CHARLES	
5. Social Security Number 215-64-5158		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.	
8. Date of Birth (Month, Day, Year) January 7, 1959		9. Birthplace (State or Foreign Country) Maryland			
10a. State Maryland		10b. County Charles		10c. City, Town or Location Brandywine	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 15110 Regina Avenue		10f. Zip Code 20613	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Independent Trucking	
17. Father's Name (First, Middle, Last) Wesley C. Pinkney		18. Mother's Name (First, Middle, Maiden Surname) Mary E. Pinkney			
19a. Informant's Name/Relationship (Type, Print) Patrick Pinkney- Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15110 Regina Ave. Brandywine, Maryland 20613			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hill Gardens		20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee Lloyd M. Estep		22. Name and Address of Facility Adams Funeral Home Aquasco, Maryland 20608			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BLUNT FORCE INJURIES OF HEAD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) UNKNOWN		28b. Time of Injury UNKNOWN M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		28e. Location (Street and Number or Rural Route Number, City or Town, State) UNKNOWN	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Joseph Pestaru M.D.		29c. License number O.C.M.E	
29d. Date signed (Month, Day, Year) MAY 26, 1999		30. Name and address of person who completed cause of death (from 23a) (Type, Print) Joseph Pestaru		31. Date filed (Month, Day, Year) JUN 01 1999	
32. Registrar's Signature B. Sparks		33. Date of Death (Month, Day, Year) MAY 25 1999		34. Time of Death 1029 P	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18715

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Veturia Ireland PROUT				2. Date of Death Month May Day 25 Year 1999		3. Time of Death 5:15 pm	
	4a. Facility Name (If not institution, give street and number) 381 West Bayfront Road				4b. City, Town, or Location of Death Lothian		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 220 36 9004		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 7, 1911	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Lothian			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 381 West Bayfront Road				10f. Zip Code 20711		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 Collega (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) teacher		16b. Kind of Business/Industry public schools		
17. Father's Name (First, Middle, Last) James Wilton Ireland				18. Mother's Name (First, Middle, Maiden Surname) Elsie Crandell				
19a. Informant's Name/Relationship (Type, Print) Earl E. Griffith (guardian)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5571 Greenock Rd., Lothian, MD 20711				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion UM Church Cem.		Date 5-28-99		20c. Location - City or Town, State Lothian, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multi-Lobar / ARDS Pneumonia Alzheimers Dementia - Advanced Multiple Contractures								Approximate Interval Between Onset and Death
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinsonism Depression Angina / ASCVD								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number DO052097		29d. Date signed (Month, Day, Year) 5/26/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janelle M. Bell MD Owings, MD 20736								
31. Date filed (Month, Day, Year) MAY 26 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18716

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>James R. Peyton</i>				2. Date of Death Month <i>May</i> Day <i>22</i> Year <i>1999</i>		3. Time of Death <i>5:50 p.m.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Southern Maryland Hospital</i>				4b. City, Town, or Location of Death <i>Clinton</i>		4c. County of Death <i>Prince George's</i>	
Funeral Director	5. Social Security Number <i>224-26-4222</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <i>74</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>April 28, 1926</i>	9. Birthplace (State or Foreign Country) <i>Virginia</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Charles</i>		10c. City, Town or Location <i>White Plains</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>P.O. Box 38</i>				10f. Zip Code <i>20695</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1943-1946</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i> College (1-4or 5+) <i>N/A</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Engineer</i>			16b. Kind of Business/Industry <i>Train/Transportation</i>	
17. Father's Name (First, Middle, Last) <i>Sam Louis Peyton</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mary M. Breeden</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Thelma V. Peyton (Wife)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P.O. Box 38 White Plains Maryland 20695</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Ft. Lincoln Cemetery</i>		Date <i>May 27, 1999</i>		20c. Location - City or Town, State <i>Brentwood, Maryland</i>
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735</i>				
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Bilateral Pneumonia</i> Due to (or as a consequence of): <i>Diffuse large B cell lymphoma</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Acute myocardial infarction</i>								Approximate Interval Between Onset and Death <i>10 days</i> <i>2 months</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute myocardial infarction</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <i>N/A</i> <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>814730</i>		29d. Date signed (Month, Day, Year) <i>5/23/1999</i>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Kai-Yin Yeung MA, 8826 Woodyard Road Suite 201 Clinton, MD 20735</i>								
31. Date filed (Month, Day, Year) <i>MAY 26 1999</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10/10

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18717

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Barry Proctor, Sr.						2. Date of Death Month Day Year May 23, 1999		3. Time of Death 12:15AM		
	4a. Facility Name (If not institution, give street and number) 5714 Linda Lane						4b. City, Town, or Location of Death Camp Springs		4c. County of Death Prince George		
Funeral Director	5. Social Security Number 217-74-7048		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 7, 1960		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Md.		10b. County Prince George		10c. City, Town or Location Camp Springs				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 5714 Linda Lane				10f. Zip Code 20748		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: American Indian			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled			16b. Kind of Business/Industry N/A				
17. Father's Name (First, Middle, Last) James Gwynn Proctor, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Mildred Elizabeth Harley					
19a. Informant's Name/Relationship (Type, Print) Mary B. Proctor (Wife)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5714 Linda Lane Camp Springs, Maryland 20748					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Maryland		20d. Date May 27, 1999			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHF, HIV Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Art. Pr. H220 SSA										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Oral Candidiasis Dementia								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred							
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Abulhasan U. Ansari, M.D.				29c. License number 0024208		29d. Date signed (Month, Day, Year) 5-24-99					
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Abulhasan U. Ansari, M.D. 8926 Woodyard Rd. #101 Clinton, Md. 20735											
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18718

Division of Vital Records, P.O. Box 68760,

Shirley C. Smith 2201 S 3 YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18719

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY L. RICHARDSON						2. Date of Death Month Day Year MAY 22, 1999		3. Time of Death 03:56 pm	
	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				4b. City, Town, or Location of Death TAKOMA PARK		4c. County of Death MONTGOMERY COUNTY			
Funeral Director	5. Social Security Number 578-22-0415		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) APR. 2, 1921		9. Birthplace (State or Foreign Country) VIRGINIA	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County PRINCE GEORGE'S		10c. City, Town or Location HYATTSVILLE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 5721 29TH AVENUE, APT. #102						10f. Zip Code 20782		10g. Citizen of What Country? UNITED STATES		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (14 or 5+) College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES CLERK				16b. Kind of Business/Industry RETAIL		
17. Father's Name (First, Middle, Last) GEORGE R. HOLMES						18. Mother's Name (First, Middle, Maiden Surname) LILLIE JOHNSON				
19a. Informant's Name/Relationship (Type, Print) MILDRED COLVIN, NIECE						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 ALLISTON STREET, BRENTWOOD, MARYLAND 20722				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CEMETERY		Date 5/25/99		20c. Location - City or Town, State BRENTWOOD, MARYLAND		
21. Signature of Funeral Service Licensee Sharon E. Welles						22. Name and Address of Facility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 week
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIGH BLOOD PRESSURE								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier DR JEFFREY KELMAN MD				29c. License number 20391		29d. Date signed (Month, Day, Year) May 24, 1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR JEFFREY KELMAN 6525 BELCROFT ROAD HYATTSVILLE, MD 20702										
31. Date filed (Month, Day, Year) MAY 25 1999			32. Registrar's Signature B. Jones							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

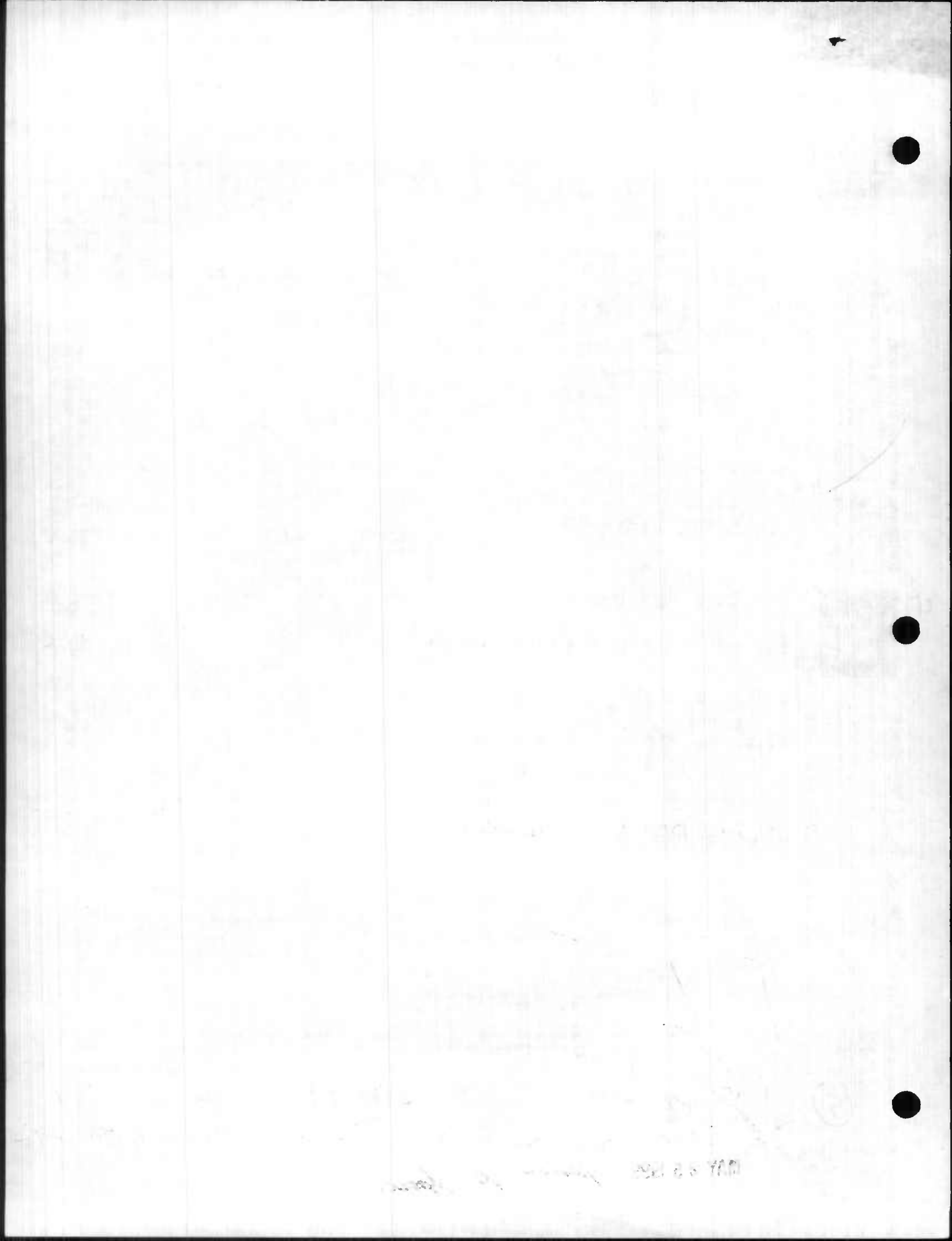
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

(5)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99-18720

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Serena Rohrbach

2. Date of Death

Month Day Year
May 23, 1999

3. Time of Death

4:33 am

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

218-20-0903

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 20, 1904

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4410 Oglethorpe Street, #304

10f. Zip Code

20781

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Customer Service

16b. Kind of Business/Industry

Washington Suburban
Sanitary Commission

17. Father's Name (First, Middle, Last)

William Frederick Scherer

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte M. Fuller

19a. Informant's Name/Relationship (Type, Print)

Lois Farias - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4410 Oglethorpe St., #304, Hyattsville, MD 20781

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

05/24/99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Henry L. Farris

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardio Respiratory arrest

Due to (or as a consequence of):

b. End Stage Renal failure

Due to (or as a consequence of):

c. Congestive Heart failure

Due to (or as a consequence of):

d. Dehydration

Approximate
Interval Between
Onset and Death

5 min

1 wk

1 wk

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

N/A

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Martin Sunde, MD

29c. License number

D050514

29d. Date signed (Month, Day, Year)

5/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mehru Master Sunde, MD 6570 Kenilworth ave Suite 200, Riverdale, MD

31. Date filed (Month, Day, Year)

MAY 24 1999

32. Registrar's Signature

B. Spade

20737

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18721

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARRIE G. ROBINSON						2. Date of Death Month Day Year May 19, 1999		3. Time of Death 7:15 PM	
	4a. Facility Name (If not institution, give street and number) Mariner Health Care of Bethesda						4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-26-7966		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 4, 1905		9. Birthplace (State or Foreign Country) Wheaton, Md.	
	Usual Residence of Decedent									
10a. State D.C.		10b. County N/A		10c. City, Town or Location Washington				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1414 Upshur Street N.W., #103						10f. Zip Code 20011		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elevator Operator				16b. Kind of Business/Industry D. C. Government		
17. Father's Name (First, Middle, Last) Richard Gaither						18. Mother's Name (First, Middle, Maiden Surname) Caroline Davis				
19a. Informant's Name/Relationship (Type, Print) Bertha Gaither - Niece						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5902 Rosedale Drive, Chillum, MD 20782				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery 5-24-99 Suitland, MD		Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Marshall's Funeral Home, Inc. 4308 Suitland Road, Suitland, Maryland 20746						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pancreatic Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostrate Cancer Dementia Hypertension								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier 				29c. License number DO 3581		29d. Date signed (Month, Day, Year) 5/20/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliot R. Goldstein, M.D. 9410 Old Georgetown Road, Bethesda, MD 20814										
State Registrar		31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18722

Certificate of Death

Reg. No.

1732
577-03-5722
5/23/99
577-03-5722
Rosenberger Ruth

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAISY RUTH ROSENBERGER				2. Date of Death Month Day Year MAY 23, 1999		3. Time of Death 1732
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER
Funeral Director	5. Social Security Number 577-03-5722	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 9, 1908	9. Birthplace (State or Foreign Country) NORTH CAROLINA
	Usual Residence of Decedent						
10a. State MARYLAND		10b. County WORCESTER		10c. City, Town or Location BERLIN		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number #1 MEADOW ST. APT. 215				10f. Zip Code 21811		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME	
17. Father's Name (First, Middle, Last) CHARLES CRANE UREN				18. Mother's Name (First, Middle, Maiden Surname) SARAH FLAKE			
19a. Informant's Name/Relationship (Type, Print) SALLY SMITH - DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #29 ALTON POINT BERLIN, MARYLAND 21811			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) STONEWALL MEMORY GARDENS		Date 5/27/99		20c. Location - City or Town, State MANASSAS, VIRGINIA	
21. Signature of Funeral Service Licensee B. Keitt Phyllis CFSP				22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. UGI Bleed / Sepsis Due to (or as a consequence of): b. Acute Myocardial Infarction Due to (or as a consequence of): c. Sepsis / Septic Shock Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 24 hrs.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① possible CVA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. Matzaro MD		29c. License number H0053714		29d. Date signed (Month, Day, Year) May 24th, 1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jeffrey Mutzoni, D.O. 9714 Healthway Drive Berlin, MD 21811							
31. Date filed (Month, Day, Year) 05 MAY 25 1999		32. Registrar's Signature B. Sparks					

Handwritten signature and date: MAY 3 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18723

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET ROWE				2. Date of Death Month Day Year MAY 19 1999		3. Time of Death 2327																											
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO																											
Funeral Director	5. Social Security Number 065-10-6398		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 23, 1914																											
	9. Birthplace (State or Foreign Country) WEST VIRGINIA		10a. State NJ		10b. County BERGEN		10c. City, Town or Location TEANECK																											
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1020 WINDSOR RD.		10f. Zip Code 07666		10g. Citizen of What Country? USA																											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BEAUTICIAN		16b. Kind of Business/Industry COSMETOLOGY																													
	17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN) ASTALOSH																													
	19a. Informant's Name/Relationship (Type, Print) ANITA WELSCH - DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11225 BEVERLY ST., BISHOPVILLE, MD 21813																													
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) EMTOMBMENT		20b. Place of Disposition (Name of cemetery, crematory, or other place) HACKENSACK MAUSELEUM		Date 5-24-99		20c. Location - City or Town, State HACKENSACK, NJ																											
	21. Signature of Funeral Service Licensee George M Short				22. Name and Address of Facility SHORT FUNERAL SERVICES P.O. BOX 233, MILTON, DE 19968																													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>PNEUMONIA</td> <td>3 DAYS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>SEPSIS</td> <td>2 DAYS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td>CVA/STROKE</td> <td>3 WEEKS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	PNEUMONIA	3 DAYS	Due to (or as a consequence of):			b.	SEPSIS	2 DAYS	Due to (or as a consequence of):			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	CVA/STROKE	3 WEEKS	Due to (or as a consequence of):			d.			Due to (or as a consequence of):		
	Immediate Cause (Final disease or condition resulting in death)	a.	PNEUMONIA	3 DAYS																														
Due to (or as a consequence of):																																		
b.		SEPSIS	2 DAYS																															
Due to (or as a consequence of):																																		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	CVA/STROKE	3 WEEKS																															
	Due to (or as a consequence of):																																	
	d.																																	
	Due to (or as a consequence of):																																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																																		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																												
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																		
29b. Signature and title of certifier Nikun				29c. License number 547094		29d. Date signed (Month, Day, Year) 5/21/99																												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. NATESAN, M.D. 106 MILFORD STREET SALISBURY, MD 21804																																		
31. Date filed (Month, Day, Year) MAY 21 1999		32. Registrar's Signature Benita B Sparks																																

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18724

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDGAR

RENSHAW

2. Date of Death

Month Day Year
MAY 23, 1999

3. Time of Death

1245 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick Calvert

4c. County of Death

Mississippi

5. Social Security Number

577-58-5843

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
NOV 12 1913

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State
Maryland10b. County
Calvert10c. City, Town or Location
Solomons

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

506 Aldergate Ct. Box 515

10f. Zip Code

20688

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

43-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Edgar Polk Renshaw

18. Mother's Name (First, Middle, Maiden Surname)

Stella Eunice Tanner

19a. Informant's Name/Relationship (Type, Print)

Dora Mae Renshaw- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as # 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

National Memorial Park

Date

May 26 1999

20c. Location - City or Town, State

Falls Church Virginia

21. Signature of Funeral Service Licensee

B Rausch

22. Name and Address of Facility

Rausch Funeral Home PA

4405 Broomes Is. Rd. Port Republic MD 20677

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMOTHORAX

a. Due to (or as a consequence of):

unk

COPD

b. Due to (or as a consequence of):

unk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHF

CAD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph J. Barth

29c. License number

D52242

29d. Date signed (Month, Day, Year)

5/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH J. BARTH, III, M.D., PRINCE FREDERICK, MD 20678

State
Registrar

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten notes, mostly illegible due to fading. Some words like "The" and "and" are visible.

Handwritten notes, mostly illegible due to fading. Some words like "The" and "and" are visible.

Handwritten notes, mostly illegible due to fading. Some words like "The" and "and" are visible.

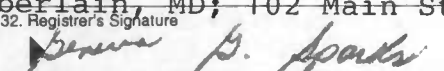
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18725

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roland Herbert Ross				2. Date of Death Month Day Year May 18, 1999		3. Time of Death 10:50AM	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 479-32-3770		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 6, 1932	9. Birthplace (State or Foreign Country) Iowa
	Usual Residence of Decedent							
10a. State Md.		10b. County Queen Anne's		10c. City, Town or Location Queenstown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 104 Lake Drive				10f. Zip Code 21658		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1952		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Safety & Cargo Director		16b. Kind of Business/Industry Anchor Motor Freight		
17. Father's Name (First, Middle, Last) Herbert Ross				18. Mother's Name (First, Middle, Maiden Surname) Beulah Kahl				
19a. Informant's Name/Relationship (Type, Print) Nancy A. Ross (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Lake Drive, Queenstown, Md. 21658				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Memorial Park		Date May 21, 1999		20c. Location - City or Town, State Easton, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md.				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardiomyopathy Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 4 yrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D37064		29d. Date signed (Month, Day, Year) 5/20/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) James M. Chamberlain, MD; 102 Main St., Stevensville, Md. 21666								
31. Date filed (Month, Day, Year) MAY 20 1999		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18726

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE SPRIGGS				2. Date of Death Month Day Year MAY 26 1999		3. Time of Death 8:10 pm		
	4a. Facility Name (If not institution, give street and number) KNOLLWOOD MANOR GENESIS ELDER CARE				4b. City, Town, or Location of Death MILLERSVILLE		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 216-18-5874		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) MAY 13 1913		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GAMBRILLS		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1074 MD. RT. 3 SOUTH		10f. Zip Code 21054		10g. Citizen of What Country? US	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANIC		16b. Kind of Business/Industry A.A. COUNTY HIGHWAY DIVISION		17. Father's Name (First, Middle, Last) GEORGE SPRIGGS SR.		18. Mother's Name (First, Middle, Maiden Surname) LOUISE QUEEN	
19a. Informant's Name/Relationship (Type, Print) WINIFRED WATKINS (NEICE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1072 MD. RT. 3 SOUTH GAMBRILLS, MD. 21054					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) WILSON MEM CHURCH CEME.		20c. Location - City or Town, State 6/1/99 GAMBRILLS, MD.			
21. Signature of Funeral Service Licensee Harry D. Reese				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST STREET ANNAPOLIS, MD. 21401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Acute Cardiopulmonary arrest Due to (or as a consequence of): b. Atherosclerotic Cardiovascular disease years Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier John M.D.				29c. License number D25000	
29d. Date signed (Month, Day, Year) May 27, 1999				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HO-HSIE HUNG, M.D. 1916 Crain Hwy. 54. #8 Glen Burnie, Md. 21061					
31. Date filed (Month, Day, Year) JUN 01 1999				32. Registrar's Signature Beverly B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

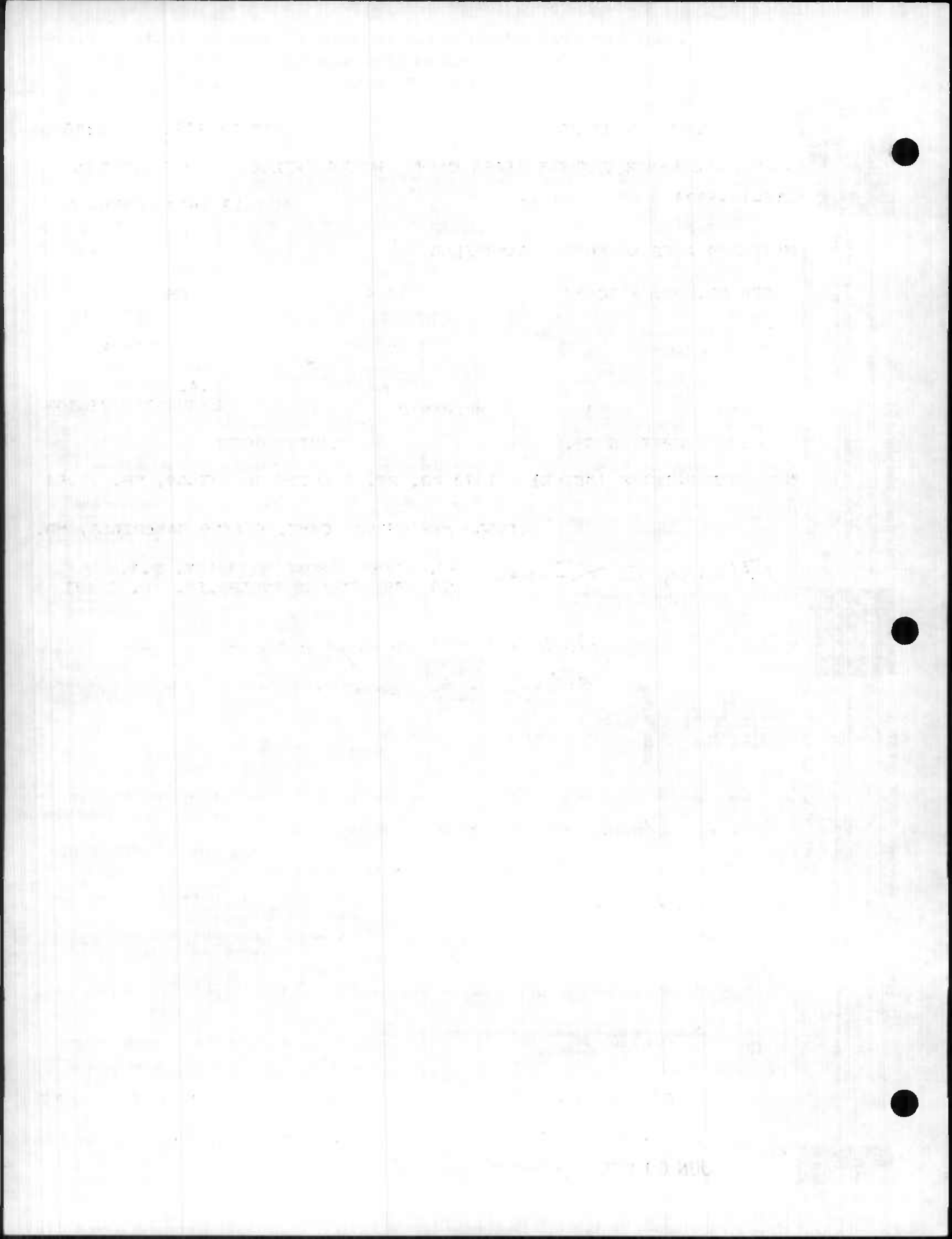
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

39 18727

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harold P Stone				2. Date of Death Month Day Year May 26 1999		3. Time of Death 10:30 PM	
	4a. Facility Name (If not institution, give street and number) Balto VAMC Extended Care Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 227-342250		6. Sex M <input type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 4, 1930	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Edgewater	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3519 Loch Haven Drive		10f. Zip Code 21037		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1949-53		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General Contractor		16b. Kind of Business/Industry Construction		17. Father's Name (First, Middle, Last) Harold William Stone		
18. Mother's Name (First, Middle, Maiden Surname) Emily Chauncey		19a. Informant's Name/Relationship (Type, Print) Martha R. Stone/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3519 Loch Haven Drive Edgewater, Maryland 21037		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem'l. Gardens		20c. Location - City or Town, State 6-1-99 Davidsonville, MD		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alzheimer's Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 6 years		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		
29c. License number 037070		29d. Date signed (Month, Day, Year) 5/26/99		30. Name and address of Person who completed cause of death (Item 23a) (Type, Print) David J Loreck MD, Balto VAMC Extended Care, 3900 Loch Raven		31. Data filed (Month, Day, Year) JUN 01 1999		
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

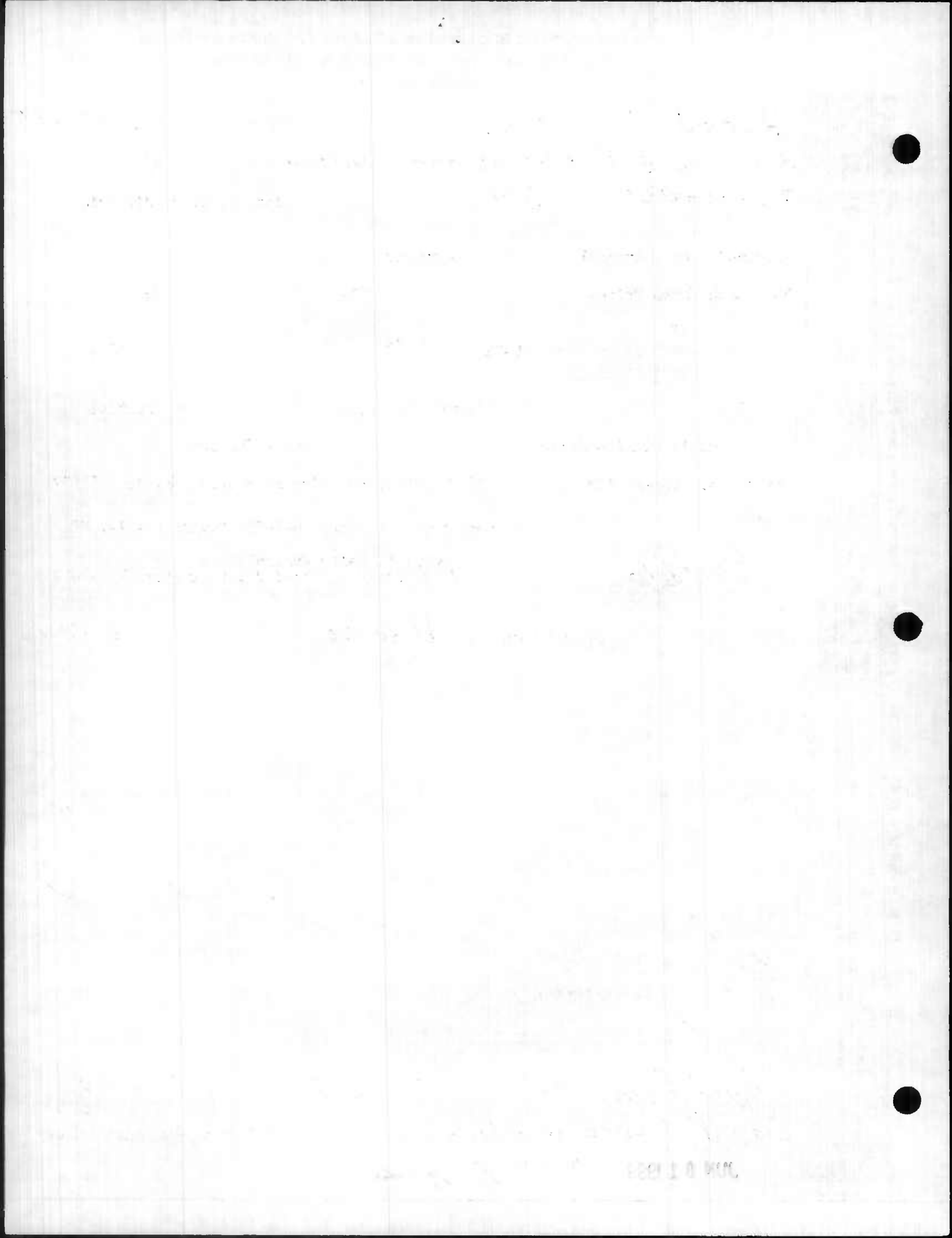
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

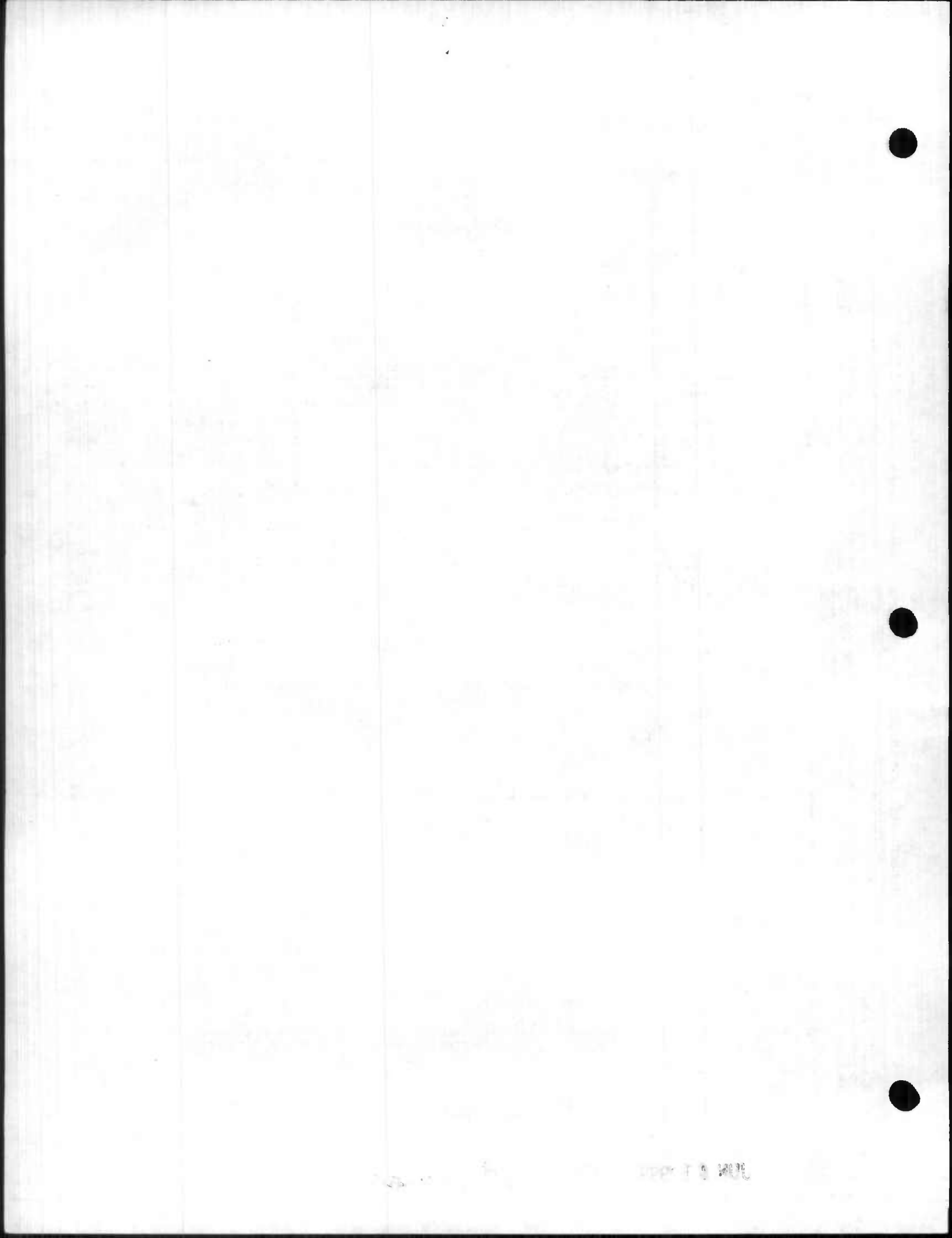
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18728

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Drake Stouffer				2. Date of Death Month Day Year May 28, 1999				3. Time of Death 8:03 A.M.	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 217-16-5362		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 23, 1910		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Riva				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 2821 Whitehouse Road				10f. Zip Code 21140		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs.				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Department Chief			16b. Kind of Business/Industry Washington Suburban Sanitary Commission		
	17. Father's Name (First, Middle, Last) Elmer C. Kresge				18. Mother's Name (First, Middle, Maiden Summa) Jennie Barkman					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Katharyn S. Freeman/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11705 Cuckold Creek Rd. Newburg, MD 20664					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem'l. Gardens		20c. Location - City or Town, State 6-4-99 Davidsonville, MD			
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): 2 hours b. Coronary Artery Disease Due to (or as a consequence of): 20 years c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Hip Fracture									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier S. Loph 2/8				29c. License number 038687			29d. Date signed (Month, Day, Year) 5/28/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sperden Jay Katz M.D. 139 OLD SOLOMON'S ISLAND RD ANNAPOLIS MD 21401										
State Registrar	31. Date filed (Month, Day, Year) JUN 01 1999				32. Registrar's Signature B. Sparks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18729

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Milfred Emerson Sears				2. Date of Death Month Day Year May 23 1999		3. Time of Death 2:45PM	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare - Spa Creek Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 215-32-8571		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 2, 1935	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 25 Bristol Drive		10f. Zip Code 21401		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry U.S. Postal Service			
	17. Father's Name (First, Middle, Last) Milfred Hill Sears				18. Mother's Name (First, Middle, Maiden Surname) Rebecca Wiley			
	19a. Informant's Name/Relationship (Type, Print) J'Neil Sears / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Bristol Drive Annapolis, MD 21401			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery		20c. Location - City or Town, State Annapolis, MD			
	21. Signature of Funeral Service Licensee C. Brian Powell				22. Name and Address of Facility 147 Duke of Gloucester St. Annapolis, Maryland 21401 John M. Taylor FH, Inc.			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic non small cell lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and Title of certifier Peter R. Grage MD		29c. License number D16364		29d. Date signed (Month, Day, Year) 5/24/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter R. Grage MD 900 Bestgate Rd, Annapolis, MD 21401								
31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18730

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NORA SHANNON				2. Date of Death Month Day Year May 23 1999		3. Time of Death 5:17pm				
	4a. Facility Name (If not institution, give street and number) 5525 Old Washington Road				4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll				
Funeral Director	5. Social Security Number 422-34-5323		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) Yrs. 68		8. Date of Birth (Month, Day, Year) July 27 1930				
	9. Birthplace (State or Foreign Country) Alabama		10a. State Md		10b. County Carroll		10c. City, Town or Location Sykesville				
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 5525 Old Washington Road		10f. Zip Code 21784		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) legal secretary		16b. Kind of Business/Industry clerical							
17. Father's Name (First, Middle, Last) Almos J. Edwards				18. Mother's Name (First, Middle, Maiden Surname) Lethro Vincent Raley							
19a. Informant's Name/Relationship (Type, Print) Donna Parlette (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5525 Old Washington Rd., Sykesville, Md 21784							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Md Anatomical Board		Date 5-23-99		20c. Location - City or Town, State Baltimore, Md					
21. Signature of Funeral Service Licensee Page Haight Herbert				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. METASTATIC OVARIAN CANCER Due to (or as a consequence of):				Approximate Interval Between Onset and Death					
b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier James L. Forsberg, MD		29c. License number D33561		29d. Date signed (Month, Day, Year) 05/26/99					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES L. FORSBERG, MD 912 WASHINGTON ROAD WESTMINSTER		31. Date filed (Month, Day, Year) MAY 26 1999		32. Registrar's Signature Barbara B. Sparks		MD 21157					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

[Faint, illegible handwriting throughout the page]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18731

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Edward Schmieder

2. Date of Death

Month Day Year
May 28 1999

3. Time of Death

0235

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

076-22-1314

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 2, 1928

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

105 B. Courtney Drive

10f. Zip Code

21921

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retail Manager

16b. Kind of Business/Industry

Goodyear Tires

17. Father's Name (First, Middle, Last)

Frank Schmieder

18. Mother's Name (First, Middle, Maiden Surname)

Rosenberg

19a. Informant's Name/Relationship (Type, Print)

Lisa Marie Schmieder, daughter 292 Old Chestnut Road, Elkton, Maryland 21921

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. Ferris & Co. Inc.

Date

5/29/99 West Chester, Pennsylvania

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Andrew G. Gee Funeral Home
259 E. Main Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. acute myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary atherosclerosis

Due to (or as a consequence of):

5 yrs

c. COPD

Due to (or as a consequence of):

7 yrs

d. Emphysema

7 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D04023

29d. Date signed (Month, Day, Year)

5/28/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JUI CHH HSU 223 West main st. Elkton MD 21921

State
Registrar

31. Date filed (Month, Day, Year)

JUN 01 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wallace Eugene Stumpf

2. Date of Death

Month Day Year
May 25, 1999

3. Time of Death

8:45 pm

4a. Facility Name (If not institution, give street and number)

5206 Iroquois Road

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216-30-4959

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 10, 1934

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10e. State

Florida

10b. County

Palm Beach

10c. City, Town or Location

West Palm Beach

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6909 69th Way

10f. Zip Code

33407

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Business Manager

16b. Kind of Business/Industry

Steamfitters Union #602

17. Father's Name (First, Middle, Last)

Herbert Conrad Stumpf

18. Mother's Name (First, Middle, Maiden Surname)

Leah Hathaway Wallace

19a. Informant's Name/Relationship (Type, Print)

Deborah J. Gudelsky - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5206 Iroquois Road, Bethesda, Maryland 20816

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

05/28/99

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non-Hodgkin's Lymphoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Daughter's Residence

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. P. Libre MD

29c. License number

D09470

29d. Date signed (Month, Day, Year)

May 27, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Eugene P. Libre, M.D., 10400 Connecticut Avenue, #606, Kensington, MD 20895

31. Date filed (Month, Day, Year)

MAY 28 1999

Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

15

Handwritten signature or initials.

6601 8 3 YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18733

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT K. SHEPPARD

2. Date of Death

Month
05Day
22Year
99

3. Time of Death

2:45 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

579-36-3641

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
February 21, 1929

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

1924 Mitchellville Road

10f. Zip Code

20716

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Worker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Willie Sheppard

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Thomas

19a. Informant's Name/Relationship (Type, Print)

Bruce T. Williams/Nephew-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1924 Mitchellville Road, Mitchellville, Maryland 20716

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

05/25
1999

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perconte

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis
Due to (or as a consequence of):b. Pneumonia
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Decubitus Ulcers

Drug Use

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural 5 ☐ Pending investigation
☐ Accident 6 ☐ Could not be determined
☐ Suicide
☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Physician

29c. License number

D47518

29d. Date signed (Month, Day, Year)

5-22-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theresa Buckner Anne Franklin Cathedral St Annapolis, MD 21401

31. Date filed (Month, Day, Year)

MAY 26 1999

32. Registrar's Signature

B. Spauld

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

[Handwritten signature]

MAY 2 1952

ROBERT F. SILVER Jr.

ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-21-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

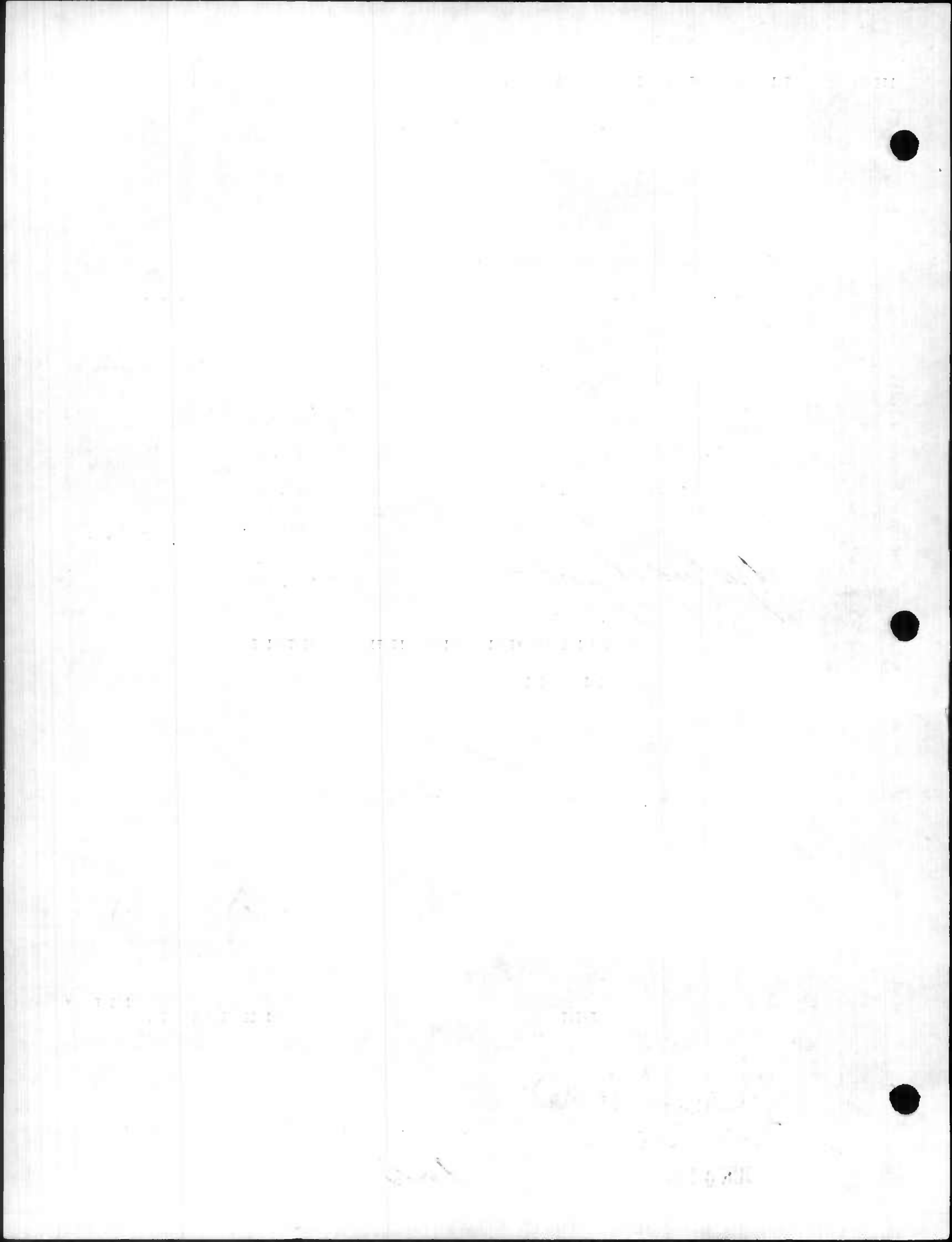
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18734

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert F. Silver Jr.				2. Date of Death Month MAY Day 23 Year 1999		3. Time of Death 2157 PM	
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL				4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 217-84-1921		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct 21 1963	9. Birthplace (State or Foreign Country) Orth Carolina
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince Georges	
To Be Completed by Funeral Director	10c. City, Town or Location Clinton				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 9701 Temple Hill Rd.	
	10f. Zip Code 20735				10g. Citizen of What Country? U.S.A.		11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Amer. Indian	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Apprentice Electrician		16b. Kind of Business/Industry Kahler Electric Co.	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Robert F. Silver Sr.				18. Mother's Name (First, Middle, Maiden Sumama) Minnie P. Lynch			
	19a. Informant's Name/Relationship (Type, Print) Jacqueline Silver (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5717 Linda Lane Camp Springs, MD 20748			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Sylver Cemetery		20c. Location - City or Town, State 6/1/99 Hollister, N.C.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. CARDIAC ARRHYTHMIA DURING AGITATION AND RESTRAINT Due to (or as a consequence of): b. SCHIZOPHRENIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 5-23-99		28b. Time of Injury 9:57 P M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred UNKNOWN			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET				28f. Location (Street and Number or Rural Route Number, City or Town, State) 9840 PISCATAWAY ROAD PRINCE GEORGE'S CO. MD			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
To Be Completed by Physician/Medical Examiner	29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) MAY 24, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Lake, MD 111 Penn Street, Baltimore, Maryland 21201				31. Data filed (Month, Day, Year) JUN 01 1999			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature 				33. Registrar's Title B. Sparks			
	34. State Registrar JUN 01 1999				35. Registrar's Title B. Sparks			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18735

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Robert R Scharpf

2. Date of Death

May 20 1999

3. Time of Death

1050

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

220-28-0330

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01/06/33

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

918 Loch Raven Road

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Business Agent

16b. Kind of Business/Industry

Electrical

17. Father's Name (First, Middle, Last)

Christian Reinhold Scharpf

18. Mother's Name (First, Middle, Maiden Surname)

Anna M. Fleichman

19a. Informant's Name/Relationship (Type, Print)

Shirley N. Scharpf (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

918 Loch Raven Rd., Salisbury, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wicomico Memorial Park

Date

5/25/99

20c. Location - City or Town, State

Salisbury, Maryland

21. Signature of Funeral Service Licensee

David H. Thompson MO1051

22. Name and Address of Facility

Holloway Funeral Home, P.A.

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cryptococcus Neofornans Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End Stage Chronic lymphocytic leukemia 9 yrs

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph N. Grasso MD

29c. License number

020507

29d. Date signed (Month, Day, Year)

5/20/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph N. GRASSO 145 E. CARROLL ST SALISBURY, MD

31. Date filed (Month, Day, Year)

MAY 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

SHARPF, ROBERT
220-28-0330
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handwritten signature and text: *Handwritten signature* BCCI & S YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18736

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter Homer Sater				2. Date of Death Month Day Year MAY 25, 1999		3. Time of Death 0430
	4a. Facility Name (If not institution, give street and number) 7902 GREEN STREET				4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 078-12-1013	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 13, 1923	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Clinton		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 7902 Green Street		10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1968		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Technician		16b. Kind of Business/Industry USAF/ Federal Government		
Physician /Medical Examiner	17. Father's Name (First, Middle, Last) Walter Bernard Sater				18. Mother's Name (First, Middle, Maiden Surname) Mabel Rose Gawthier		
	19a. Informant's Name/Relationship (Type, Print) Walter H. Sater, Jr (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7902 Green Streer Clinton, Maryland 20735		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) May 28, 1999 Maryland State Veterans Cem.		20c. Location - City or Town, State Cheltenham, Maryland		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735				
Physician /Medical Examiner	23a. Part I: Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
	a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of):						
	b. Due to (or as a consequence of):						
	c. Due to (or as a consequence of):						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 		29c. License number D33954		29d. Date signed (Month, Day, Year) MAY 26, 1999		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLLE, JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785						
	31. Date filed (Month, Day, Year) MAY 26 1999		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18737

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothea Marie Suter						2. Date of Death Month Day Year May 8, 1999		3. Time of Death 8:40 AM													
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center						4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel													
Funeral Director	5. Social Security Number 218-09-1470		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) June 29, 1921		9. Birthplace (State or Foreign Country) Baltimore, MD													
	Usual Residence of Decedent																					
10a. State MD		10b. County Queen Anne's		10c. City, Town or Location Stevensville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
10e. Street and Number 210 Baltimore Drive						10f. Zip Code 21666		10g. Citizen of What Country? U.S.A.														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Self															
17. Father's Name (First, Middle, Last) Howard Silas Townsend						18. Mother's Name (First, Middle, Maiden Summa) Bessie Loreen Jones																
19a. Informant's Name/Relationship (Type, Print) James C. Suter - Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 Penny Lane, Stevensville, MD 21666																
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Memorial Park			20c. Location - City or Town, State May 12, 1999 Easton, MD																
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4"> Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Staphylococcal septicemia, methicillin resistant</td> <td>7 days</td> </tr> <tr> <td>b.</td> <td>urinary tract infection</td> <td>7 days</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Staphylococcal septicemia, methicillin resistant	7 days	b.	urinary tract infection	7 days	c.			d.		
Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Staphylococcal septicemia, methicillin resistant	7 days																			
	b.	urinary tract infection	7 days																			
	c.																					
	d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Diabetes mellitus type II Congestive heart failure Chronic obstructive pulmonary disease																						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred														
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																						
29b. Signature and title of certifier MD						29c. License number D0029571		29d. Date signed (Month, Day, Year) 5/8/99														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Berea MD 1655 Crofton Blvd suite 101, Crofton MD 21114																						
31. Date filed (Month, Day, Year) MAY 12 1999		32. Registrar's Signature 																				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18738

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patricia Ann Trescott				2. Date of Death Month Day Year May 20, 1999				3. Time of Death 1:18 p.m.		
	4a. Facility Name (If not institution, give street and number) Mariner Health of Glen Burnie				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 220-60-9591		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) Mar 13, 1955		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 1604 Elkwood Court				10f. Zip Code 21401				10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) YWCA Shelter Counselor				16b. Kind of Business/Industry Counseling			
17. Father's Name (First, Middle, Last) William Trescott, Jr.				18. Mother's Name (First, Middle, Maiden Surname) Ruth Rodgers							
19a. Informant's Name/Relationship (Type, Print) Ruth Trescott / mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 638 Oakland Hills Dr. B1, Arnold, MD 21012							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date May 21 1999		20c. Location - City or Town, State Baltimore, MD					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Multiple Sclerosis Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number D41927		29d. Date signed (Month, Day, Year) 5/21/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jorge Perez-Alvarado 3708 Mountain Rd Pikesville, MD 21112											
31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

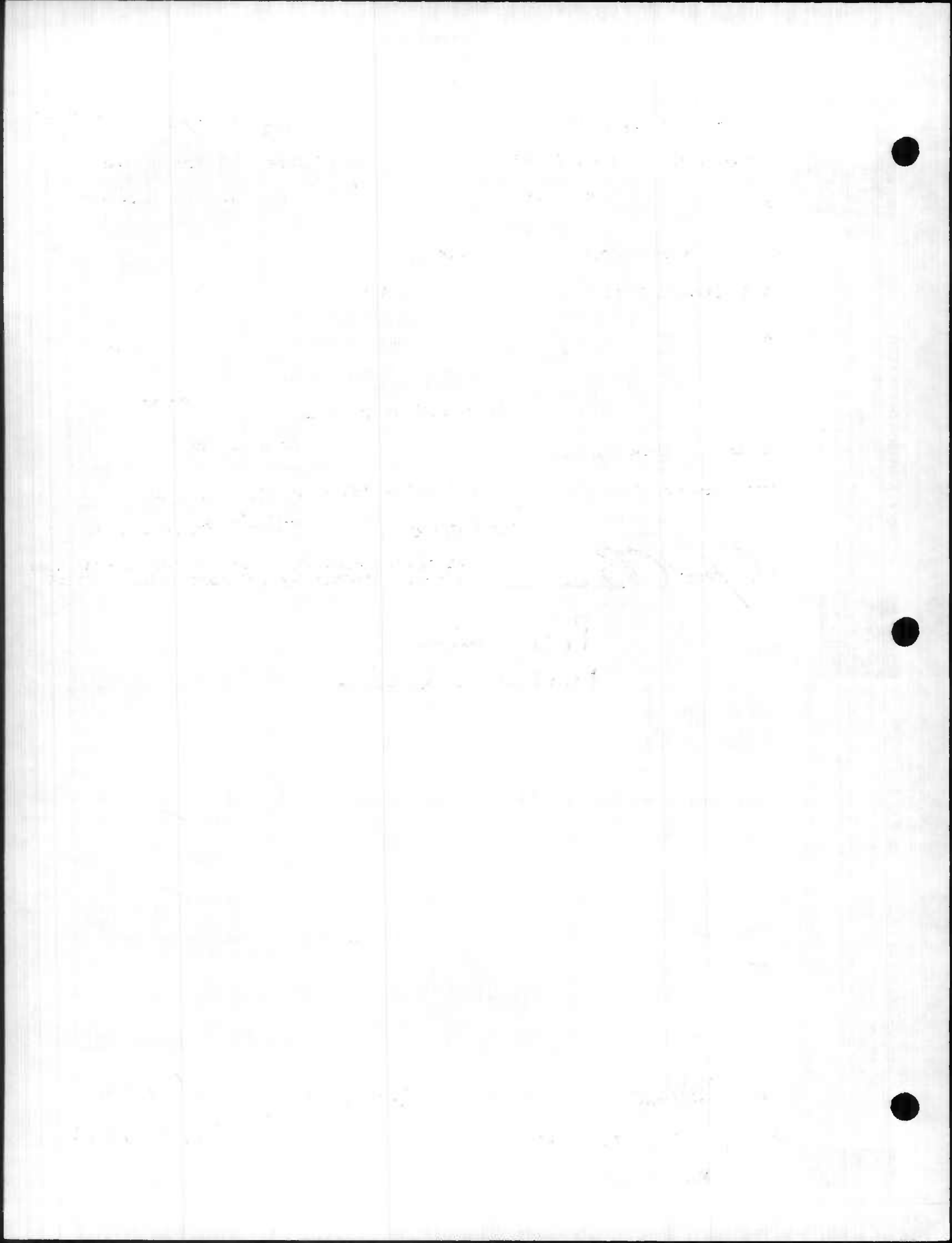
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18739

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

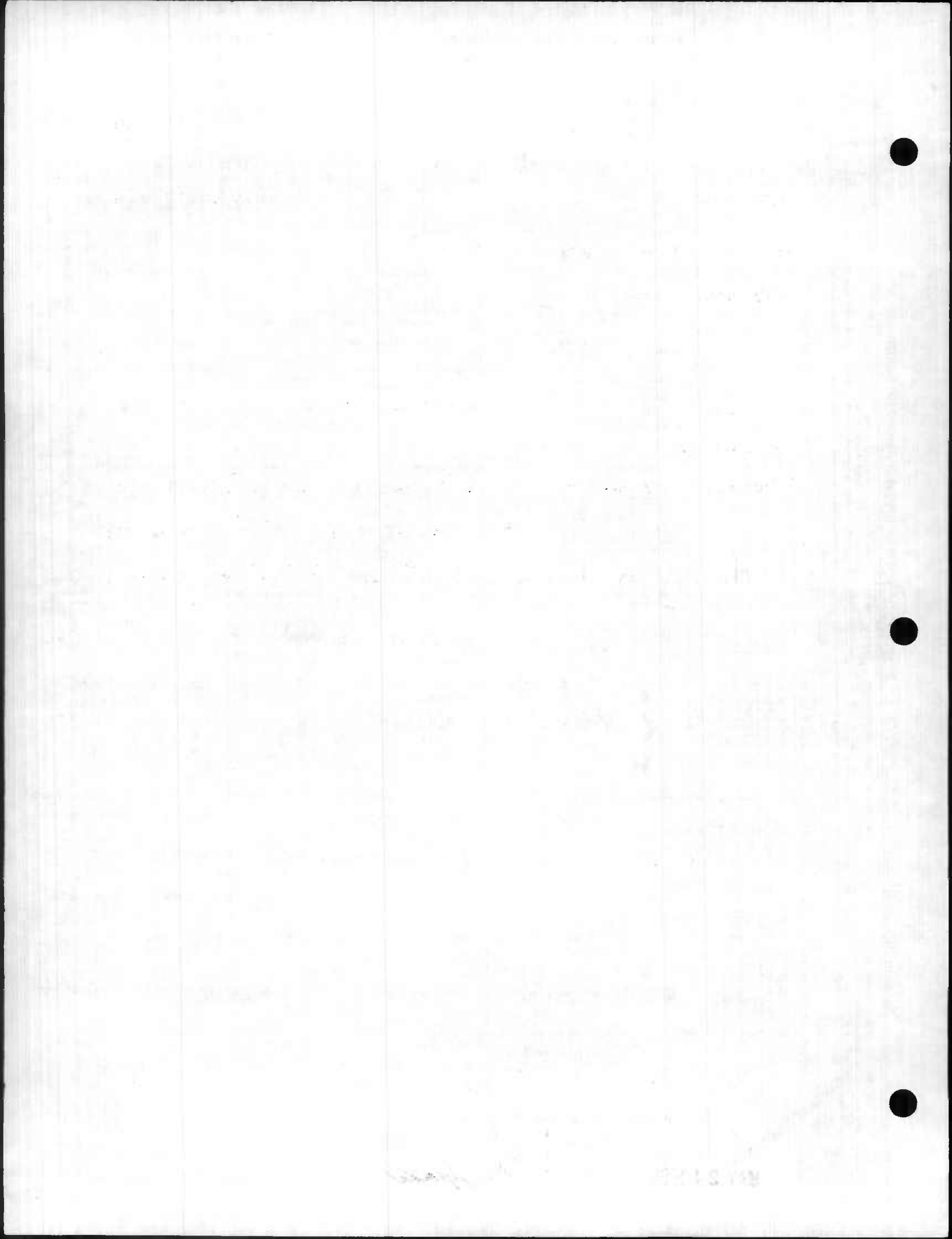
Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Lee Torrey				2. Date of Death Month 05 Day 20 Year 1999		3. Time of Death 10:10am	
4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Chesley, MD		4c. County of Death Prince George's	
5. Social Security Number 727-07-3878		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) January 27, 1929	
9. Birthplace (State or Foreign Country) Tennessee		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Landover	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2010 Barlowe Place		10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Laborer		16b. Kind of Business/Industry Private		17. Father's Name (First, Middle, Last) Philip Torrey	
18. Mother's Name (First, Middle, Maiden Surname) (Unknown)		19a. Informant's Name/Relationship (Type, Print) Paulette Torrey/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2010 Barlowe Place, Landover, Maryland 20785		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hills Cemetery		20c. Location - City or Town, State Clinton, Maryland		21. Signature of Funeral Service Licensee Nancy A. Perentie		22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Acute respiratory distress syndrome Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Pulmonary edema Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1 DAY 1 DAY 1 DAY		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate cancer with metastases Chronic obstructive pulmonary disease				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier [Signature]		29c. License number 00053680		29d. Date signed (Month, Day, Year) 5/20/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PG Hospital, Dept of Int. Med., 3001 Hospital Dr, Chesley, MD, 20785	
31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature [Signature]					

4



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18740

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) George T. Thomas						2. Date of Death Month May Day 27 Year 1999			3. Time of Death 4:42pm	
4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center						4b. City, Town, or Location of Death Clinton			4c. County of Death Prince Georges	
5. Social Security Number 214-18-8132		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1921 September 9,		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent										
10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Brandywine				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 18041 Cedarville Road			10f. Zip Code 20613			10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Skilled Labor			16b. Kind of Business/Industry Construction			
17. Father's Name (First, Middle, Last) James R. Thomas						18. Mother's Name (First, Middle, Maiden Surname) Theresa Edelen				
19a. Informant's Name/Relationship (Type, Print) Mary Washington- Daughter						19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4242 Rail Street Capital Heights Maryland 20743				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hill Gardens			Date June 3, 1999		20c. Location - City or Town, State Clinton, Maryland		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Adams Funeral Home Aquasco, Maryland 20608				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Aspiration pneumonia a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Resp. insufficiency Encephalopathy										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street end Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number 046478			29d. Date signed (Month, Day, Year) 5-28-99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh A. Patel MD 7501 Surratts Rd # 307 Clinton, MD 20735										
31. Date filed (Month, Day, Year) JUN 01 1999		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHERMAN LEE TIVIS

2. Date of Death

Month 5 Day 20 Year 99

3. Time of Death

2235h

4a. Facility Name (If not institution, give street and number)

CARROLL COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

Funeral
Director

5. Social Security Number

443-12-0909

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) MAY 27, 1921

9. Birthplace (State or Foreign Country)

OKLAHOMA

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

11 SULLIVAN AVE., APT. C

10f. Zip Code

21157

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

TRANSPORTATION

17. Father's Name (First, Middle, Last)

JOHN B. TIVIS

18. Mother's Name (First, Middle, Maiden Surname)

PEARL CADELL

19a. Informant's Name/Relationship (Type, Print)

WAYNE TIVIS - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 SULLIVAN AVE., APT. C, WESTMINSTER, MD. 21157

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

5/24/99

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

FLETCHER FUNERAL HOME
254 E. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE BRONCHOSPASM

Due to (or as a consequence of):

b. END-STAGE EMPHYSEMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D25203

29d. Date signed (Month, Day, Year)

5/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.T. MORROW MD, 300 MEMORIAL DR, WESTMINSTER MD 21157
C.T. MORROW MD, CARROLL COUNTY GENERAL HOSPITAL

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18742

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LESTER AEDRON TAYLOR					2. Date of Death Month May Day 18 Year 1999		3. Time of Death 2116	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER					4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 215-72-3588		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 13, 1956		9. Birthplace (State or Foreign Country) SALIS, MARYLAND
	Usual Residence of Decedent								
10a. State VIRGINIA			10b. County ACCOMACK		10c. City, Town or Location NEW CHURCH			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 30449 CHINCOTEAGUE RD.					10f. Zip Code 23415		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) POULTRY FARMER			16b. Kind of Business/Industry POULTRY INDUSTRY	
17. Father's Name (First, Middle, Last) BILLY BURTON TAYLOR					18. Mother's Name (First, Middle, Maiden Surname) JEANETTE HALL				
19a. Informant's Name/Relationship (Type, Print) BILLY B. TAYLOR - FATHER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6456 LANKFORD HIGHWAY NEW CHURCH, VA 23415				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) DOWNING'S CEMETERY			Date 5/22/99	20c. Location - City or Town, State OAK HALL, VIRGINIA		
21. Signature of Funeral Service Licensee <i>B. Keist</i>					22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Cardiogenic shock									minutes
Due to (or as a consequence of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Acute myocardial infarction									hours
Due to (or as a consequence of):									
c. Coronary artery disease									years
Due to (or as a consequence of):									
d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. Signature and title of certifier <i>Steph Paulos MD</i>		29c. License number D41721		29d. Date signed (Month, Day, Year) 05/18/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHAN PAULOS, MD. 400 EASTERN SHORE DRIVE, SALISBURY, MD. 21804									
31. Date filed (Month, Day, Year) MAY 21 1999			32. Registrar's Signature <i>Benita B Sparks</i>						

LESTER TAYLOR 215-72-3588

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

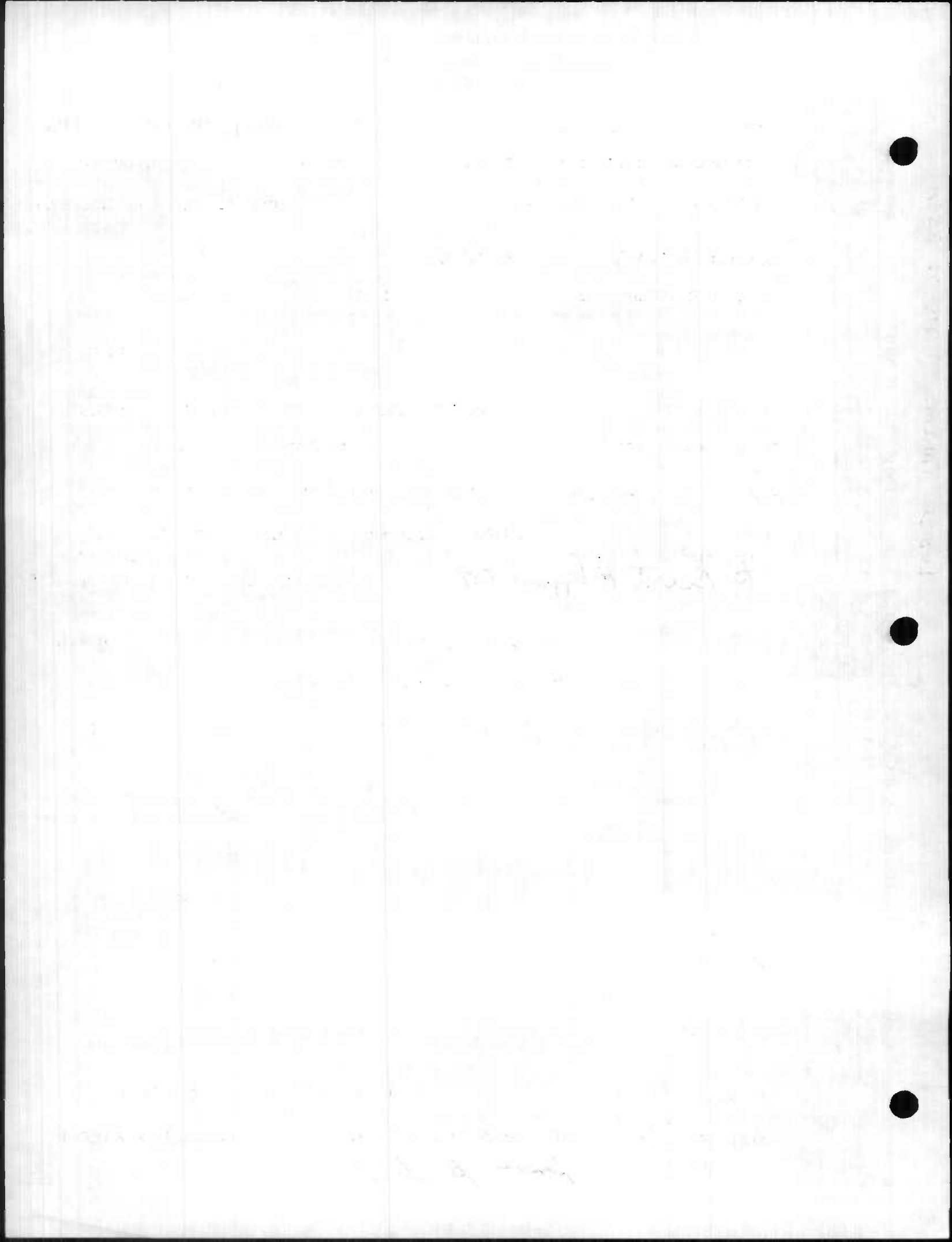
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

card
6State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

18743

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vincent Uy				2. Date of Death Month May Day 17 Year 1999				3. Time of Death 7:50 PM	
	4a. Facility Name (If not institution, give street and number) 7500 Burnt Wood Court				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 219 29 2760		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 36 Yrs.		8. Date of Birth (Month, Day, Year) Sept 27, 1962		9. Birthplace (State or Foreign Country) Philippines	
	Usual Residence of Decedent				10a. State MD		10b. County P.G.		10c. City, Town or Location Clinton	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 7500 Burnt Wood Court		10f. Zip Code 20735		10g. Citizen of What Country? Philippines Citizen	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Asian (Filipino)	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Manager				16b. Kind of Business/Industry Nordstrom	
	17. Father's Name (First, Middle, Last) Benjamin S. Uy				18. Mother's Name (First, Middle, Maiden Surname) Visitacion R. Talucad					
	19a. Informant's Name/Relationship (Type, Print) Jean M. Uy (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7500 Burnt Wood Court, Clinton, Maryland 20735					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Date May 21, 1999		20c. Location - City or Town, State Clinton, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Carcinoid Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 2 Years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown X	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number 21020		
29d. Date signed (Month, Day, Year) May 18, 1999				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vera Malkovska, M.D. 110 Irving Street, N.W. Suite 2151, Washington DC 20010						
31. Date filed (Month, Day, Year) MAY 20 1999				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #26, daughter's residence, 5/25/99 **Certificate of Death**

Reg. No.

99 18744

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace Agnes Vallandingham					2. Date of Death Month May Day 12 Year 1999			3. Time of Death 5:00 PM		
	4a. Facility Name (If not institution, give street and number) 326 Marlin Court					4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 579-32-7816		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 30, 1927		9. Birthplace (State or Foreign Country) Washington, DC		
	Usual Residence of Decedent										
10e. State Maryland		10b. County St. Mary's		10c. City, Town or Location Clements				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 22398 Budds Creek Road					10f. Zip Code 20624			10g. Citizen of What Country? U. S. A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) Grason C. Moore					18. Mother's Name (First, Middle, Maiden Surname) Mary C. Donohoe						
19a. Informant's Name/Relationship (Type, Print) Kathy Purvis, Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3939 B Gamber Road, Finksbury, Maryland 21048						
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Francis Xavier Cemetery		Date 5/17/99		20c. Location - City or Town, State Compton, Maryland			
21. Signature of Funeral Service Licensee <i>Reginald NE</i>					22. Name and Address of Facility Takoma Funeral Home, Inc. 254 Carroll St. NW, Washington, DC 20012						
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of the Pancreas Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death Months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) daughter's residence								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>William D. Boyd II</i>					29c. License number D-14285			29d. Date signed (Month, Day, Year) 5-13-99			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William D. Boyd II, M. D. Leonardtown, Maryland 20650											
31. Date filed (Month, Day, Year) MAY 25 1999					32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

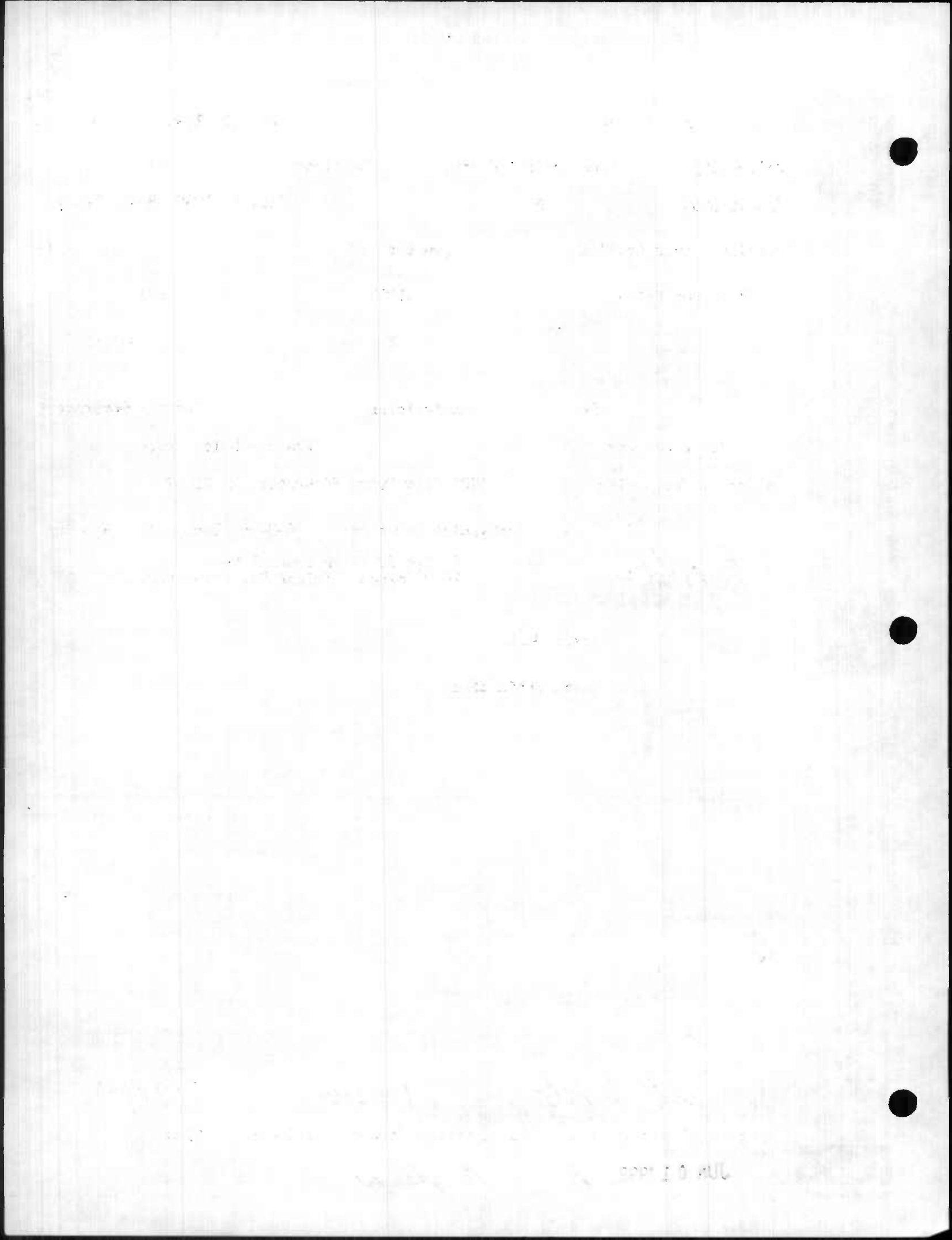
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18746
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert J. Walton				2. Date of Death Month Day Year May 20, 1999		3. Time of Death 10:40 P.M.	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 219-16-2278		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 24, 1912	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Davidsonville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 906 Governor Bridge Road		10f. Zip Code 21035		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self employed		16b. Kind of Business/Industry Waste Removal			
	17. Father's Name (First, Middle, Last) Robert T. Walton				18. Mother's Name (First, Middle, Maiden Surname) Lillie Maude Fields			
	19a. Informant's Name/Relationship (Type, Print) Ethel E. Walton/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 Governor Bridge Road Davidsonville, MD 21035			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 5-22-99 Alexandria, Virginia			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart failure Due to (or as a consequence of): Coronary artery disease Diabetes mellitus				Approximate Interval Between Onset and Death two months unknown unknown			
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Colitis villous adenomata of colon prostate cancer							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Colitis villous adenomata of colon prostate cancer				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of Certifier 		29c. License number 044161		29d. Date signed (Month, Day, Year) 5-21-99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Patricia Czapp, MD 900 Bestgate Rd. Suite 303 Annapolis, MD 21401								
31. Date filed (Month, Day, Year) MAY 24 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

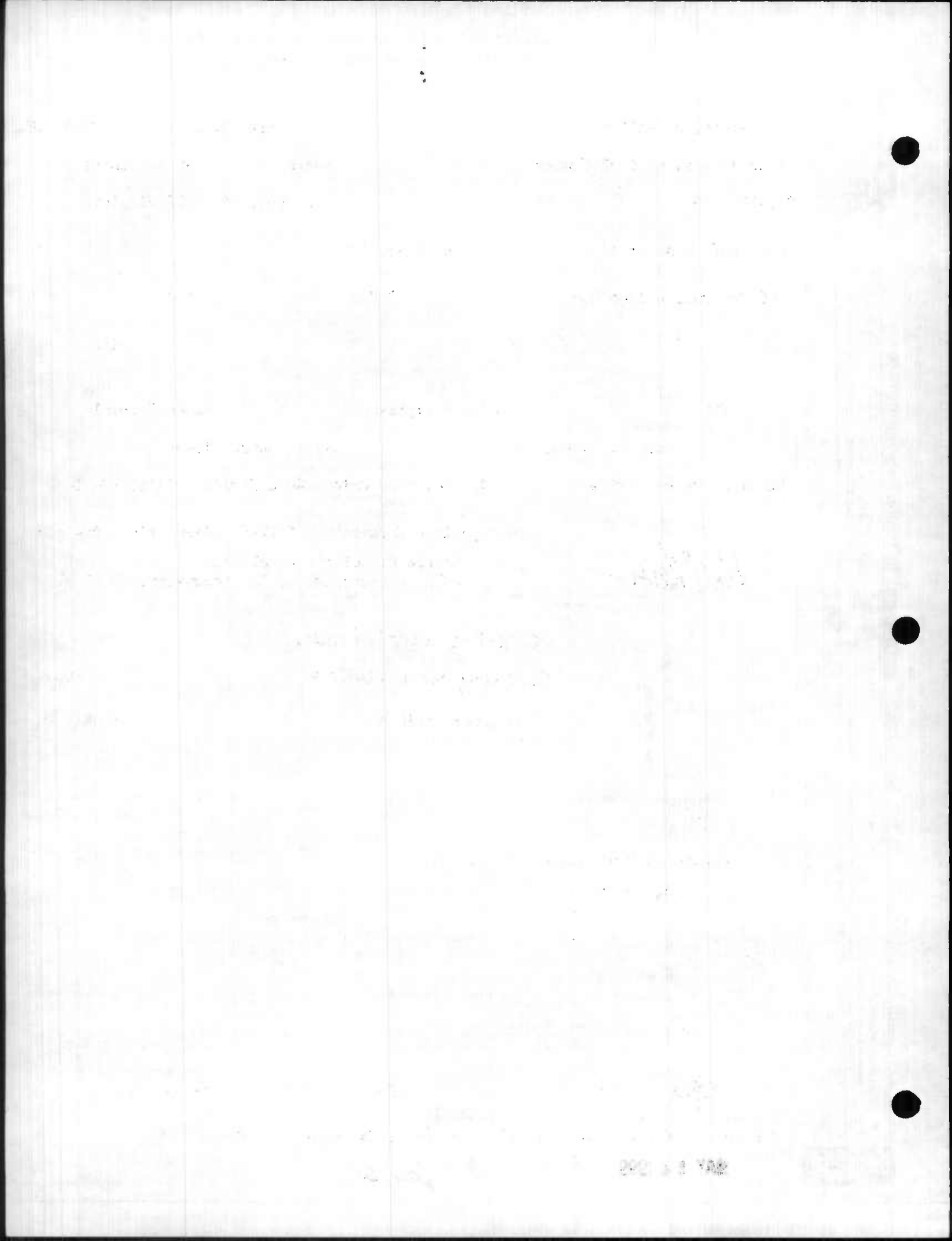
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



99-2979-510
99-112

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

GORDON WARHURST ITEMS: #23 PART I, 27 PER MEO G772 6-1 **Certificate of Death**

Reg. No.

99 18747

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gordon V. Warhurst				2. Date of Death Month Day Year MAY 22, 1999		3. Time of Death 3:09P.M.	
	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-28-7592		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Jan 14, 1931	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1101 N. Calvert Street #704		10f. Zip Code 21102		
10g. Citizen of What Country? USA		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Representative		16b. Kind of Business/Industry Bethlehem Steel		
17. Father's Name (First, Middle, Last) William Warhurst				18. Mother's Name (First, Middle, Maiden Surname) Margaret Cornthwaite				
19a. Informant's Name/Relationship (Type, Print) Frances McNelly / sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108 765 Spring Bloom Drive, Millersville, MD				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date May 26 1999		20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 23, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAY 26 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3-2-77

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #1. Per Phys. PGC 6-7-99 cr

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bessie M. Wiley				2. Date of Death Month: May 21, 1999 Year: 2030		3. Time of Death	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-40-3880		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month: April Day: 13 Year: 1922	9. Birthplace (State or Foreign) Louisiana
	Usual Residence of Decedent							
10a. State D.C.		10b. County		10c. City, Town or Location Washington			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 1413 Ives Place, S.E.				10f. Zip Code 20003		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper			16b. Kind of Business/Industry Domestic	
17. Father's Name (First, Middle, Last) William Ayers					18. Mother's Name (First, Middle, Maiden Surname) Leola Wagner			
19a. Informant's Name/Relationship (Type, Print) Mrs. Venus Y. Ashton (Grand-Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 Deep Gorge Court Oxon Hill, Maryland 20745			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 5/28/99		20c. Location - City or Town, State Brentwood, Maryland
21. Signature of Funeral Service Licensee <i>Alfred J. Chellin</i>					22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>URO sepsis</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <i>3 days</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Type II Diabetes Mellitus</i> <i>Atrial Fibrillation</i> <i>Coronary atherosclerosis</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier <i>P. Angen</i>		29c. License number D35045
29d. Date signed (Month, Day, Year) 22 May 99								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Philip G. Henjum, MD 3416 Olwood Court #204 Olney MD 20832</i>								
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature <i>B. Spaul</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

✓



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18749

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louise D. Wood

2. Date of Death

Month

Day

Year

May

21

1999

3. Time of Death

7:12 PM

4a. Facility Name (If not institution, give street and number)

Heron Point

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral
Director

5. Social Security Number

056-12-0029

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 2 1916

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

229 Heron Point, Chestertown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

229 Heron Point

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Legal

17. Father's Name (First, Middle, Last)

George L. Davis

18. Mother's Name (First, Middle, Maiden Surname)

Laura Klock

19a. Informant's Name/Relationship (Type, Print)

Charles F. Wood

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

229 Heron Point, Chestertown, MD 21620

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hockessin Crematory Co. 5/27/99

Date

20c. Location - City or Town, State

Hockessin, DE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Chandler Funeral Homes
2506 Concord Pike, Wilmington, DE 19803

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ALL HERMANS ALUMINUM DIALYZER
Dua to (or as a consequence of):

Approximate Interval Between Onset and Death

10 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d. Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? (JHH SP20Y)

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined☐ Could not be determined☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H-13844

29d. Date signed (Month, Day, Year)

5-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John C. Seymour, Heron Point, 501 Campus Avenue, Chestertown, MD 21620

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18750

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David W. Weatherman

2. Date of Death

Month
MayDay
24Year
1999

3. Time of Death

10:40 PM

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

231-24-1118

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 7, 1927

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

421 Sylmar Rd.

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shop Foreman

16b. Kind of Business/Industry

Henkels & McCoy

17. Father's Name (First, Middle, Last)

Samuel Weatherman

18. Mother's Name (First, Middle, Maiden Surname)

Laura Grubb

19a. Informant's Name/Relationship (Type, Print)

Juanita G. Weatherman/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

421 Sylmar Rd. Rising Sun, MD 21911

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rosebank Cemetery

Date

5-27-99

20c. Location - City or Town, State

Rising Sun, Maryland

21. Signature of Funeral Service Licensee

Richard L. Goodie

22. Name and Address of Facility

R. T. Foard Funeral Home, P. A.
111 S. Queen St., Rising Sun, MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

ACUTE MYOCARDIAL INFARCTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERLIPIDEMIA

GASTRO ESOPHAGEAL REFLUX DS.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

T. H. H. H. H.

29c. License number

B42800

29d. Date signed (Month, Day, Year)

5/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. H. H. H. H., 318 S. Union Ave., H&B, MD, 21078

31. Date filed (Month, Day, Year)

MAY 27 1999

32. Registrar's Signature

B. B. B.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18751

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Pearl Elizabeth Wood				2. Date of Death Month Day Year May 25, 1999		3. Time of Death 8:25PM												
4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's												
5. Social Security Number 577-84-2010		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 8, 1909												
9. Birthplace (State or Foreign Country) Maryland																		
Usual Residence of Decedent																		
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capitol Heights		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No												
10e. Street and Number 5415 Brenner St.				10f. Zip Code 20743		10g. Citizen of What Country? USA												
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry At Home												
17. Father's Name (First, Middle, Last) William Penn				18. Mother's Name (First, Middle, Maiden Surname) Unknown														
19a. Informant's Name/Relationship (Type, Print) Russell Wood/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10														
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 5/28/99		20c. Location - City or Town, State Suitland, Maryland												
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, MD. 20745														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Atherosclerotic Disease</td> <td rowspan="4"> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death </td> </tr> <tr> <td>b.</td> <td>Congestive Heart Failure</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Atherosclerotic Disease	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.	Congestive Heart Failure	c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Atherosclerotic Disease	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death														
	b.	Congestive Heart Failure																
	c.																	
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Valve Replacement Anticoagulant Therapy						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown												
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)														
28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier 				29c. License number D 52310		29d. Date signed (Month, Day, Year) 5/25/99												
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Christopher Ervin, M.D. 3001 Hospital Dr. Cheverly, MD. 25785																		
31. Date filed (Month, Day, Year) MAY 28 1999				32. Registrar's Signature 														

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

8

Handwritten signature

MAY 3 1958

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99-18752

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MELVIN E. WEDGE, SR.

2. Date of Death

05-25-99

3. Time of Death

08.50 PM.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

215-20-3101

6. Sex

1X M 2 F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03-31-27

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Suitland

10d. Inside City Limits

1X Yes 2 F No

10e. Street and Number

6224 Suitland Rd.

10f. Zip Code

20746

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 F Never Married 2X Married

3 F Widowed 4 F Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 F No

If Yes, Give Year or Dates: 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 F Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Golf Marshall

16b. Kind of Business/Industry

Golfing Enterprise

17. Father's Name (First, Middle, Last)

William Henry Wedge

18. Mother's Name (First, Middle, Maiden Surname)

Emma Makle

19a. Informant's Name/Relationship (Type, Print)

Melody Atkinson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7712 Tinkers Creek Dr., Clinton, Md. 20735

20a. Method of Disposition

1X Burial 2 F Cremation 3 F Removal from State

4 F Donation 5 F Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cem. 5/29/99

Date

20c. Location - City or Town, State

Clinton, Md.

21. Signature of Funeral Service Licensee

Larry N. Pratt

22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Approximate Interval Between Onset and Death

10-15 days

a. Due to (or as a consequence of):

Renal Failure

2-3 wks.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ca Prostat.

23b. Did tobacco use contribute to the cause of death?

1 F Yes 2X No 3 F Probably 4 F Unknown

24a. Was an autopsy performed?

1 F Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1 F Yes 2 F No

25. Was case referred to medical examiner?

1 F Yes 2X No

Hospital:

1X Inpatient 2 F ER/Outpatient 3 F DOA

26. Place of Death (Check only one)

Other: 4 F Nursing Home 5 F Residence 6 F Other (Specify)

27. Manner of Death

1X Natural 5 F Pending investigation
2 F Accident 6 F Could not be determined
3 F Suicide
4 F Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 F Yes 2 F No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 F Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pratt MD Attending

29c. License number

042580

29d. Date signed (Month, Day, Year)

5-26-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5638 Annapolis Rd #13 Bladensburg, MD 20710.

31. Date filed (Month, Day, Year)

MAY 27 1999

32. Registrar's Signature

B. Apate

State
Registrar

Baltimore, Maryland 21215-0020

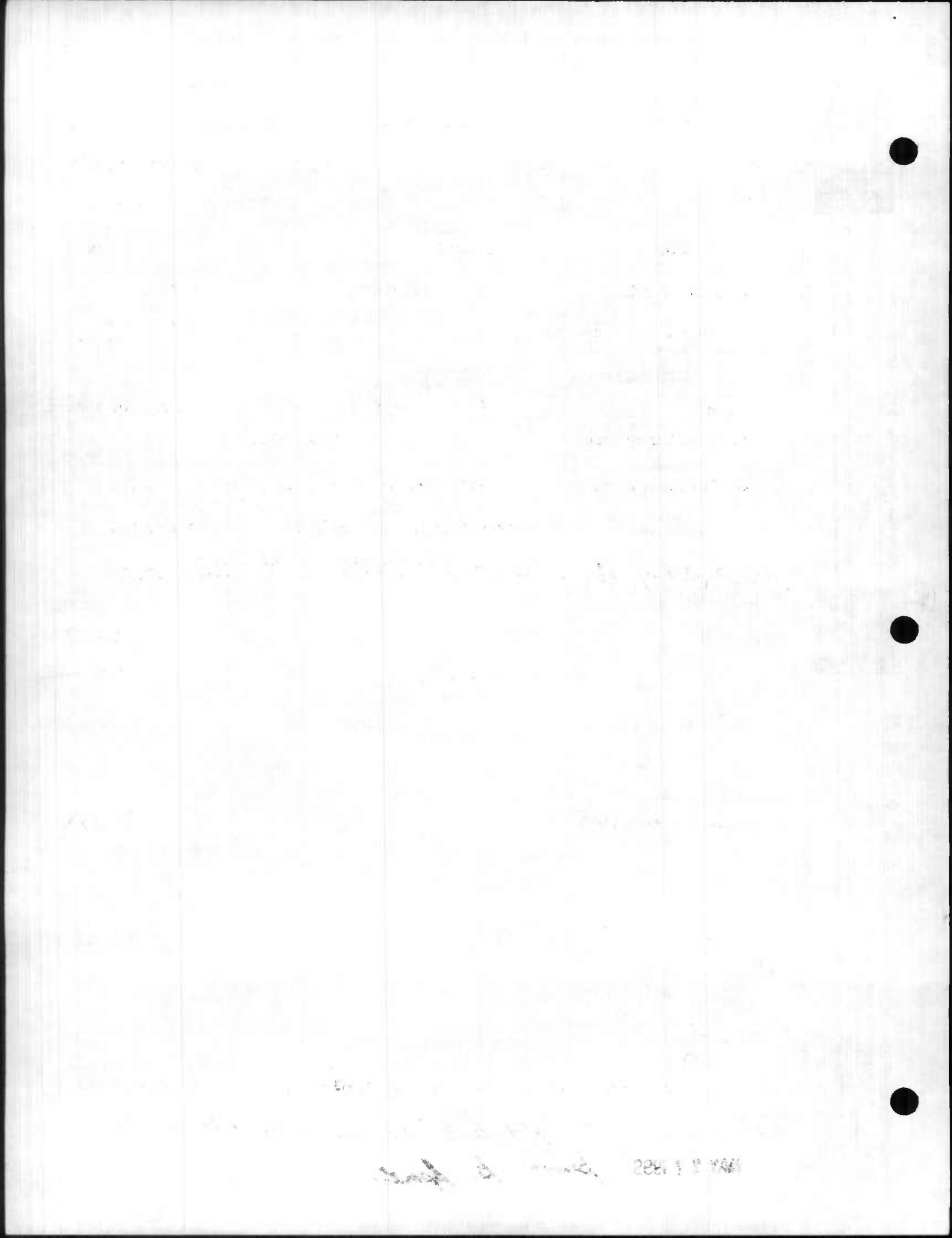
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18753

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Whitehead				2. Date of Death Month Day Year May 23 1999				3. Time of Death 130 PM		
	4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Center				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 578-52-6497		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 18, 1939		9. Birthplace (State or Foreign Country) Wash., D.C.		
	10a. State Maryland				10b. County Prince George's		10c. City, Town or Location Landover		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1403 Capitol View Terrace											
10f. Zip Code 20785											
10g. Citizen of What Country? United States											
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nursing				16b. Kind of Business/Industry Government			
17. Father's Name (First, Middle, Last) William M. Jenkins						18. Mother's Name (First, Middle, Maiden Surname) Dorothy M. Diggs					
19a. Informant's Name/Relationship (Type, Print) Jean Payne - Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Capitol View Terrace, Landover, MD 20785					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cem.		Date 5/29/99		20c. Location - City or Town, State Suitland, MD			
21. Signature of Funeral Service Licensee John T. Stewart III						22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Asthma Due to (or as a consequence of): anoxic encephalopathy Cardiac arrest. respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 days 3 days 3 days											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier J.D. Alleyne, M.D.				29c. License number D51006				29d. Date signed (Month, Day, Year) May 23rd, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Georges Hospital 3001 Hospital Drive Cheverly MD 20785											
31. Date filed (Month, Day, Year) MAY 26 1999				32. Registrar's Signature B. Sparks							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18754

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Randy Scott Wilkerson				2. Date of Death Month May Day 27 Year 1999		3. Time of Death 5:50pm		
	4a. Facility Name (If not institution, give street and number) 11529 Charles Street				4b. City, Town, or Location of Death La Plata		4c. County of Death Charles		
Funeral Director	5. Social Security Number 218-56-6922		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 16, 1950	9. Birthplace (State or Foreign Country) Wash, DC	
	Usual Residence of Decedent								
10a. State MD		10b. County Charles		10c. City, Town or Location La Plata			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 11529 Charles Street				10f. Zip Code 20646		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Education		
17. Father's Name (First, Middle, Last) Malcolm Wilkerson					18. Mother's Name (First, Middle, Maiden Surname) Jacqueline Ours Wilkerson				
19a. Informant's Name/Relationship (Type, Print) Kathryn Wilkerson/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11529 Charles St. La Plata, MD 20646					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gar.		20c. Location - City or Town, State 6/1/99 Waldorf, MD			
21. Signature of Funeral Service Licensee David C. Echols				22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA, MD 20646					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CANCER OF ESOPHAGUS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 4 yrs.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dr. Krishan M. Mathur		29c. License number 028352		29d. Date signed (Month, Day, Year) 5/28/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, MD., P.O. Box 2729, La Plata, MD 20646									
31. Date filed (Month, Day, Year) JUN 01 1999		32. Registrar's Signature James B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

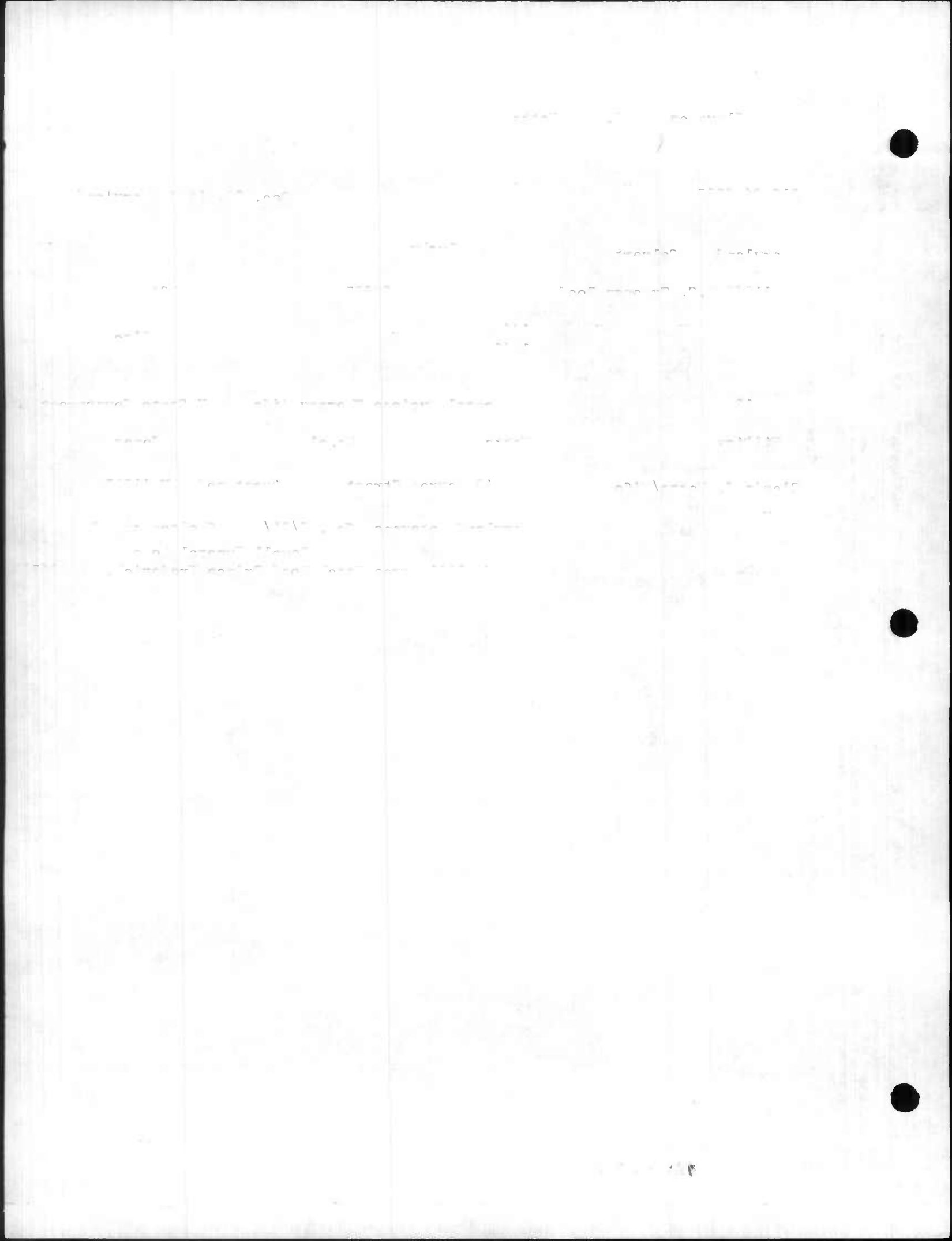
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18755

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clarence G. Watts				2. Date of Death Month Day Year May 18, 1999		3. Time of Death 8:10 A.M.	
	4a. Facility Name (If not institution, give street and number) 11509 H.G. Trueman Road				4b. City, Town, or Location of Death Lusby		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 217-36-9357		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 25, 1940	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Lusby	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 11509 H.G. Trueman Road		10f. Zip Code 20657		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1960- If Yes, Give Year or Dates: 1962		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene Therapy Aide		16b. Kind of Business/Industry NY State Government		17. Father's Name (First, Middle, Last) William Watts	
	18. Mother's Name (First, Middle, Maiden Surname) Hazel Jones		19a. Informant's Name/Relationship (Type, Print) Gloria J. Watts/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Warren Street Brentwood, NY 11717		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans' Cem.		20c. Location - City or Town, State Cheltenham, MD		21. Signature of Funeral Service Licensee Clarence G. Watts		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Clarence G. Watts		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) May 19, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Aaron L. L. L.		31. Date filed (Month, Day, Year) MAY 21 1999		32. Registrar's Signature B. Sparks		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18756

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daly Lynwood Wolfe				2. Date of Death Month Day Year May 18, 1999		3. Time of Death 9:44AM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-38-9651		6. Sex XXM 2□F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 28, 1931	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton	
To Be Completed by Funeral Director	10d. Inside City Limits 1□ Yes 2□ No		10e. Street and Number 10503 Thrift Road		10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1□ Never Married 2□ Married 3□ Widowed 4□ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1□ Yes 2□ No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2□ No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Vice Principal		16b. Kind of Business/Industry Prince George's Schools			
	17. Father's Name (First, Middle, Last) Daly Meade Wolfe				18. Mother's Name (First, Middle, Maiden Surname) Margaret Harris			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Dora G. Wolfe (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1302 Garcia Laredo, Texas 7840			
	20a. Method of Disposition 1□ Burial 2□ Cremation 3□ Removal from State 4□ Donation 5□ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Catholic Cemetery		20c. Location - City or Town, State Laredo, Texas		20d. Date May 27, 1999	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Kelli R. Patter				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATORY FAILURE SEVERE OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): PULMONARY EMPHYSEMA Due to (or as a consequence of): HEAVY CIGARETTE SMOKING Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MALNUTRITION PERNICIOUS ANEMIA BRONCHIAL ASTHMA				23b. Did tobacco use contribute to the cause of death? 1□ Yes 2□ No 3□ Probably 4□ Unknown			
	24a. Was an autopsy performed? 1□ Yes 2□ No				24b. Were autopsy findings available prior to completion of cause of death? N/A			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1□ Yes 2□ No		26. Place of Death (Check only one) Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)					
	27. Manner of Death 1□ Natural 2□ Accident 3□ Suicide 4□ Homicide 5□ Pending investigation 6□ Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1□ Yes 2□ No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Dante G. Lee, MD				29c. License number D15789		29d. Date signed (Month, Day, Year) 5-18-99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL G. LEE MD 7700 OLD BRANCA AVE, CLINTON, MD 20735							
State Registrar	31. Date filed (Month, Day, Year) MAY 20 1999				32. Registrar's Signature Dante G. Lee			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

18757

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Bismarck Wichy				2. Date of Death Month Day Year May 15, 1999				3. Time of Death 9:30 AM			
4a. Facility Name (If not institution, give street and number) 120 Queens Colony High Road				4b. City, Town, or Location of Death Stevensville				4c. County of Death Queen Anne's			
5. Social Security Number 581-68-6611		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 70		8. Date of Birth (Month, Day, Year) August 8, 1928		9. Birthplace (State or Foreign Country) Puerto Rico			
Usual Residence of Decedent											
10a. State MD		10b. County Queen Anne's		10c. City, Town or Location Stevensville				10d. Inside City Limits 1 Yes 2 No			
10e. Street and Number 120 Queens Colony High Road				10f. Zip Code 21666				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Puerto Rican				14. Race - American Indian, Black, White, etc. Specify: Hispanic			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pilot				16b. Kind of Business/Industry Military			
17. Father's Name (First, Middle, Last) Vicente Wichy						18. Mother's Name (First, Middle, Maiden Surname) Dolores Navarro					
19a. Informant's Name/Relationship (Type, Print) Grathel Banks - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Queens Colony High Road, Stevensville, MD 21666							
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery				20c. Location - City or Town, State Arlington, VA			
21. Signature of Funeral Service Licensee <i>Ameyto Michewicz</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alzheimer's										Approximate Interval Between Onset and Death 3 yr	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
24a. Were an autopsy performed? 1 Yes 2 No										24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>G. J. Sprague MD</i>				29c. License number 032036		29d. Date signed (Month, Day, Year) 5/17/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary J. Sprague MD 2108 P. Drive Drive, Chester, MD 21619											
31. Date filed (Month, Day, Year) MAY 19 1999				32. Registrar's Signature <i>G. J. Sprague</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

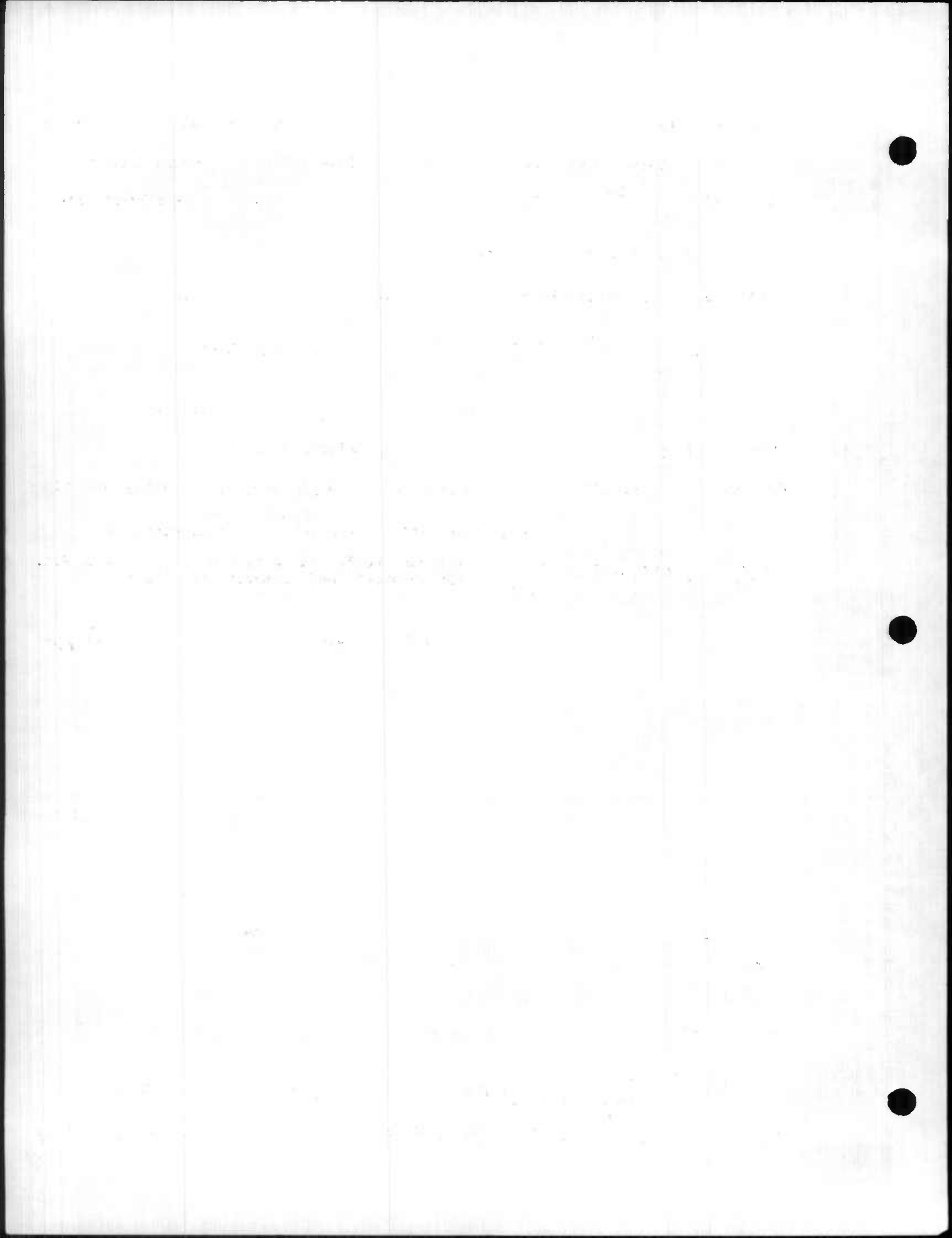
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18758

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rex Wilson Wright				2. Date of Death Month 06 Day 01 Year 1999		3. Time of Death 4:05pm	
	4a. Facility Name (If not institution, give street and number) CROMWELL CENTER- GENESIS ELDERCARE				4b. City, Town, or Location of Death BALTIMORE COUNTY		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 224-12-7199		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 21, 1917	
	9. Birthplace (State or Foreign Country) Virginia							
Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore County				10d. Inside City Limits 1 Yes 2 No
10e. Street and Number 4105 Slater Avenue				10f. Zip Code 21236		10g. Citizen of What Country? USA		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Station Owner			16b. Kind of Business/Industry Self-Employed	
17. Father's Name (First, Middle, Last) William Wright				18. Mother's Name (First, Middle, Maiden Surname) Callie Hash				
19a. Informant's Name/Relationship (Type, Print) Mr. Warren T. Wright				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4105 Slater Avenue Baltimore, Md. 21236				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. 6-4-1999		Date		20c. Location - City or Town, State Baltimore, Md.	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Atrial Fibrillation Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death one mo. one yr.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema Peripheral vascular Disease						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
						24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D0021022		29d. Date signed (Month, Day, Year) 6-3-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Kowalski 8114 SANDPIPER CIRCLE SALTWATER MD 21236								
31. Date filed (Month, Day, Year) JUN 9 1999		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18759

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Ann Zampogna				2. Date of Death Month Day Year May 19, 1999		3. Time of Death 10:09 A.M.	
	4a. Facility Name (If not institution, give street and number) 9101 Ivanhoe Road				4b. City, Town, or Location of Death Ft. Washington		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 200-32-1705		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 6, 1942	
	9. Birthplace (State or Foreign Country) Titusville, PA.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Ft. Washington	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 9101 Ivanhoe Rd.		10f. Zip Code 20744		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mother and Homemaker		16b. Kind of Business/Industry At Home				
17. Father's Name (First, Middle, Last) John J. Kush				18. Mother's Name (First, Middle, Maiden Surname) Geraldine Burnett				
19a. Informant's Name/Relationship (Type, Print) Michael J. Zampogna/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lamey Cemetery		Date 05/25/99		20c. Location - City or Town, State Dempsey Town, PA.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, MD. 20745				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PANCREATIC CARCINOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D43346		29d. Date signed (Month, Day, Year) 5/19/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITA GUPTA MD, 8926 WOODWARD ROAD #201 CLINTON MD 20735								
31. Date filed (Month, Day, Year) MAY 24 1999				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18760

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henrietta J. Zdobysz				2. Date of Death Month Day Year May 25, 1999		3. Time of Death 0840		
	4a. Facility Name (If not institution, give street and number) 4423 Reamy Drive				4b. City, Town, or Location of Death Suitland		4c. County of Death Prince George		
Funeral Director	5. Social Security Number 151-07-6426		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 23, 1916	9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Suitland		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 4423 Reamy Drive				10f. Zip Code 20746		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home			
17. Father's Name (First, Middle, Last) Jacob Sack					18. Mother's Name (First, Middle, Maiden Surname) Henrietta Roosevelt				
19a. Informant's Name/Relationship (Type, Print) Donna Miller (Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4423 Reamy Drive Suitland, Maryland 20746				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Maryland		20d. Date May 28, 1999		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Myocardial Infarction Due to (or as a consequence of): b. Cardiomyopathy Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d. Aortic Stenosis								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Hypercholesterolemia							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how Injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 					29c. License number md. D23826		29d. Date signed (Month, Day, Year) 5-25-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn R. Edgecombe M.D. 7700 Old Branch Ave. B-201 Clinton, Md. 20715									
31. Date filed (Month, Day, Year) MAY 26 1999			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18761

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS T. ANTHONY				2. Date of Death Month Day Year JUNE 9, 1999		3. Time of Death 1:22 AM		
	4a. Facility Name (If not institution, give street and number) 3000 D SEABURY ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NIA		
Funeral Director	5. Social Security Number 217-86-2156		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 28, 1960		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County NIA		10c. City, Town or Location BALTIMORE CITY		
To Be Completed by Funeral Director	10e. Street and Number 3000 D SEABURY ROAD		10f. Zip Code 21225		10g. Citizen of What Country? USA.		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH GRADE		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) JANITORIAL		16b. Kind of Business/Industry HOSPITAL		
	17. Father's Name (First, Middle, Last) HARRY ANTHONY				18. Mother's Name (First, Middle, Maiden Surname) ANNIE SIMMONS				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CLEVELAND ANTHONY (UNCLE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 D SEABURY RD., BALTIMORE, MD 21225				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. Location - City or Town, State MD-12-99 LANSDOWNE, MD.		20d. Date 06-12-99		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD 21217				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic carcinoma of the tongue Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, Type 2 Alcoholism, Hepatitis C							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier 						
	29c. License number 020040		29d. Date signed (Month, Day, Year) 6/10/99						
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James M. 700 Washington Blvd, Baltimore, MD 21230								
	31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18762

Name: Keith S. Brown
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Keith Storm Brown				2. Date of Death Month June Day 10 Year 1999		3. Time of Death 11:40 PM	
	4a. Facility Name (If not institution, give street and number) VAMHCS FORT HOWARD DIVISION				4b. City, Town, or Location of Death Fort Howard		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-46-0723		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAR 8, 1948	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Fort Howard			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9600 North Point Road				10f. Zip Code 21052		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter/Painter			16b. Kind of Business/Industry Construction	
17. Father's Name (First, Middle, Last) Walter Kirkwood Brown				18. Mother's Name (First, Middle, Maiden Surname) Mary Gladys Orr				
19a. Informant's Name/Relationship (Type, Print) Angelia Minnick/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2511 Hanson Road Edgewood, MD 21040				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 6/11/99		20c. Location - City or Town, State Baltimore, MD
21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228				
23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer (small Cell) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death Unknown
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier James B. Galicia MD				29c. License number D15698		29d. Date signed (Month, Day, Year) JUNE 10, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcos B. Galicia, MD 9600 North Point Road Fort Howard, MD 21052								
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature James B. Sparks				

ALL 10

REPORT ON THE PROGRESS OF THE WORK DURING THE YEAR 1900

The work of the Department during the year 1900 has been characterized by a steady and continuous progress in all the various branches of the service. The most important results have been the completion of the Census of the Marine Mammals, the publication of the Report on the Fishes of the Hawaiian Islands, and the completion of the work on the Fishes of the United States.

The Census of the Marine Mammals, which was completed in the month of June, 1900, is a valuable contribution to our knowledge of the distribution and habits of these animals. The Report on the Fishes of the Hawaiian Islands, which was published in the month of July, 1900, is a valuable contribution to our knowledge of the fish fauna of these islands.

The work on the Fishes of the United States, which has been completed, is a valuable contribution to our knowledge of the fish fauna of this country. The work on the Fishes of the United States, which has been completed, is a valuable contribution to our knowledge of the fish fauna of this country.

JESSICA
BLASCYK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18763

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jessica Marie Blaszczyk				2. Date of Death Month Day Year JUNE 3, 1999		3. Time of Death 1:20P.M.	
	4a. Facility Name (If not institution, give street and number) 5714 BAY VIEW PARKWAY				4b. City, Town, or Location of Death CHURCHTON		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 213-35-9722		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 13 Yrs.		8. Date of Birth (Month, Day, Year) May 8, 1986	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Churchton	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 5714 Bay View Parkway		10f. Zip Code 20733		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry School				
17. Father's Name (First, Middle, Last) Timothy Francis Blaszczyk				18. Mother's Name (First, Middle, Maiden Surname) Susan Debra Newman				
19a. Informant's Name/Relationship (Type, Print) Ronald N. Newman/Grandfather				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5714 Bay View Parkway Churchton, MD 20733				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. Date 6/9/99		20d. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Edward A. Gregorchik		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. Ruptured Appendix with peritonitis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Hayne Melkale				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 4, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hayne Melkale 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18764

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MADELEINE

LOIS

BUSTER

2. Date of Death

JUNE

8

1999

3. Time of Death

09:23PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213 36 1845

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/22/1940

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5710 KEY AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

AT&T

17. Father's Name (First, Middle, Last)

ERNEST L. TAYLOR

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE MCKINNEY

19a. Informant's Name/Relationship (Type, Print)

RENEE BANKS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 RITTER RIDGE CT. OWINGS MILLS, MD. 21117

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

DRUID RIDGE CEM.

Date

6/14/99

20c. Location - City or Town, State

BALTO., MD.

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

JAMES A. MORTON & SONS F.H., INC.

1701 LAURENS ST. BALTO., MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. SEPSIS
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

24 HOURS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. HEPATIC FAILURE
Due to (or as a consequence of):

6 DAYS

c. PRIMARY PULMONARY HYPERTENSION
Due to (or as a consequence of):

5 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Stuart M. Levine, M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JUNE 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STUART M. LEVINE, M.D. JOHNS HOPKINS HOSPITAL BALTIMORE MARYLAND

State
Registrar

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

James B. Spauld

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-358-2000.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18765

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH YVONNE BLUM				2. Date of Death Month Day Year June 9, 1999		3. Time of Death 1546		
	4a. Facility Name (If not institution, give street and number) Fallston General Hospital				4b. City, Town, or Location of Death Fallston		4c. County of Death Harford		
Funeral Director	5. Social Security Number 217-20-3674		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 12, 1923		
	9. Birthplace (State or Foreign Country) Maryland								
To Be Completed by Funeral Director	Usual Residence of Decedent								
	10a. State Maryland		10b. County Harford		10c. City, Town or Location Belcamp			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1262 Collier Lane				10f. Zip Code 21017		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yr's College (1-4 or 5+) 4 yr's		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary		16b. Kind of Business/Industry Westinghouse				
	17. Father's Name (First, Middle, Last) William Thomas Blum				18. Mother's Name (First, Middle, Maiden Surname) Frances E. Hyson				
	19a. Informant's Name/Relationship (Type, Print) Nalda A. Blum - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer		Date 6/12/99		20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee Paul L. Heston				22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.				
	23e. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PALMONARY EMBOLUS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 6 HOURS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA PERIPHERAL T CELL LYMPHOMA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier John P. Edwards, M.D.		29c. License number 231775		29d. Date signed (Month, Day, Year) JUNE 9, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN P. EDWARDS, M.D.		2112 BELAIR ROAD FALLSTON, MARYLAND 21047							
State Registrar	31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Ruth Yvonne Blum

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18766

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Bernadine Bowman				2. Date of Death Month Day Year JUNE 8 1999		3. Time of Death 5:00 AM	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Geriatric Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-05-7844		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) June 12, 1914	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
Usual Residence of Decedent								
10a. State Maryland			10b. County N/A			10c. City, Town or Location Baltimore		
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 4010 Wilke Avenue			10f. Zip Code 21206		
10g. Citizen of What Country? United States			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			17. Father's Name (First, Middle, Last) Jerome Koppleman		
18. Mother's Name (First, Middle, Maiden Surname) Anna Kuhn			19a. Informant's Name/Relationship (Type, Print) Mary Halpin / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 Deer Ridge Apt. 511 Balto., MD 21210		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cem.			20c. Location - City or Town, State 6/10/99 Baltimore, Maryland		
21. Signature of Funeral Service Licenses Timothy Harman			22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CVA Due to (or as a consequence of): Artrial Fibrillation Due to (or as a consequence of): ASCVD Due to (or as a consequence of):		
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. UTI Osteoporosis Depression			23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier WTS			29c. License number D043 P3		
29d. Date signed (Month, Day, Year) 6/8/99			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Greenough, M.D. 5505 Hopkins Bayview Circle Baltimore, MD 21224			31. Data filed (Month, Day, Year) JUN 11 1999		
32. Registrar's Signature Laura S. Sparks								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18767

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anita Mary Mullin Batzer

2. Date of Death

Month Day Year
JUNE 7, 1999

3. Time of Death

5:10 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-074946

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 18, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

2005 Hillen Wood Road

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Receptionist

16b. Kind of Business/Industry

Parochial School

17. Father's Name (First, Middle, Last)

John Thomas Mullin, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Mary Flanigan

19a. Informant's Name/Relationship (Type, Print)

Jerome G. Batzer (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2005 Hillen Wood Road, Baltimore, Maryland 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

6/10/99 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service licensee

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.

6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

ACUTE PULMONARY EDEMA

Approximate
Interval Between
Onset and Death

1 HOUR

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE CEREBRAL EMBOLISM

CORONARY HEART DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 07696

29d. Date signed (Month, Day, Year)

6/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. DAVID NAGEL, M.D., 7601 OSLER DRIVE, TOWSON, MD 21204

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18768

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Mae Long Brown</i>			2. Date of Death Month <i>June</i> Day <i>04</i> Year <i>1999</i>		3. Time of Death <i>0955am</i>		
	4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Center</i>			4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>		
Funeral Director	5. Social Security Number <i>187-20-4028</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>80</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year <i>3-20-19</i>	
	9. Birthplace (State or Foreign Country) <i>S. CAROLINA</i>							
To Be Completed by Funeral Director	10a. State <i>MARYLAND</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>5009 FRANKFORT</i>		10f. Zip Code <i>21206</i>		10g. Citizen of What Country? <i>U.S.A</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>NURSING ASSISTANT</i>		16b. Kind of Business/Industry <i>PRIVATE AGENCY</i>			
	17. Father's Name (First, Middle, Last) <i>UNKNOWN</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>UNKNOWN</i>				
	19a. Informant's Name (Relationship, Type, Print) <i>LAQUINIA HYRES</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1605 E. LAFAYETTE AVE. BALTIMORE, MD.</i>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GARRISON-Forest</i>		20c. Location - City or Town, State <i>6-14-99 OWINGS Mills, MD.</i>			
	21. Signature of Funeral Service Licensee <i>Cynthia Palmer</i>			22. Name and Address of Facility <i>JOSEPH G. LOCKS, JR. 1302 N. CENTRAL AVE. BALTO. MD. 21204</i>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <i>Aspiration pneumonia</i> Due to (or as a consequence of): b. <i>Seizure disorder</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							<i>16 days</i> <i>1 year</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Phyllis M. Lammert, MD</i>		29c. License number <i>97486</i>		29d. Date signed (Month, Day, Year) <i>June 04, 1999</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Suzanne M. Caccamesse 4940 Eastern Avenue Baltimore, Maryland 21224</i>								
31. Date filed (Month, Day, Year) <i>JUN 11 1999</i>		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18769

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leonard Moses Berke

2. Date of Death

Month Day Year
June 10, 1999

3. Time of Death

12:31AM.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

125-03-2927

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11-21-17

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

12135 Trailridge Dr.

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW11

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Economic Advisor

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Gershon Berkowitz

18. Mother's Name (First, Middle, Maiden Surname)

Helen Rogowska

19a. Informant's Name/Relationship (Type, Print)

Jennifer B. Levin/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

215 Tower La, Penn Valley, PA. 19072

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King David Memorial

Date

6/11

20c. Location - City or Town, State

Falls Church, VA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Takoma Funeral Home.

254 Carroll St. NW. Washington, DC. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Cardiopulmonary arrest
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. intracranial hemorrhage
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

050962

29d. Date signed (Month, Day, Year)

6/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. David Taragin 1025 Fernwood Rd #301

Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

J. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

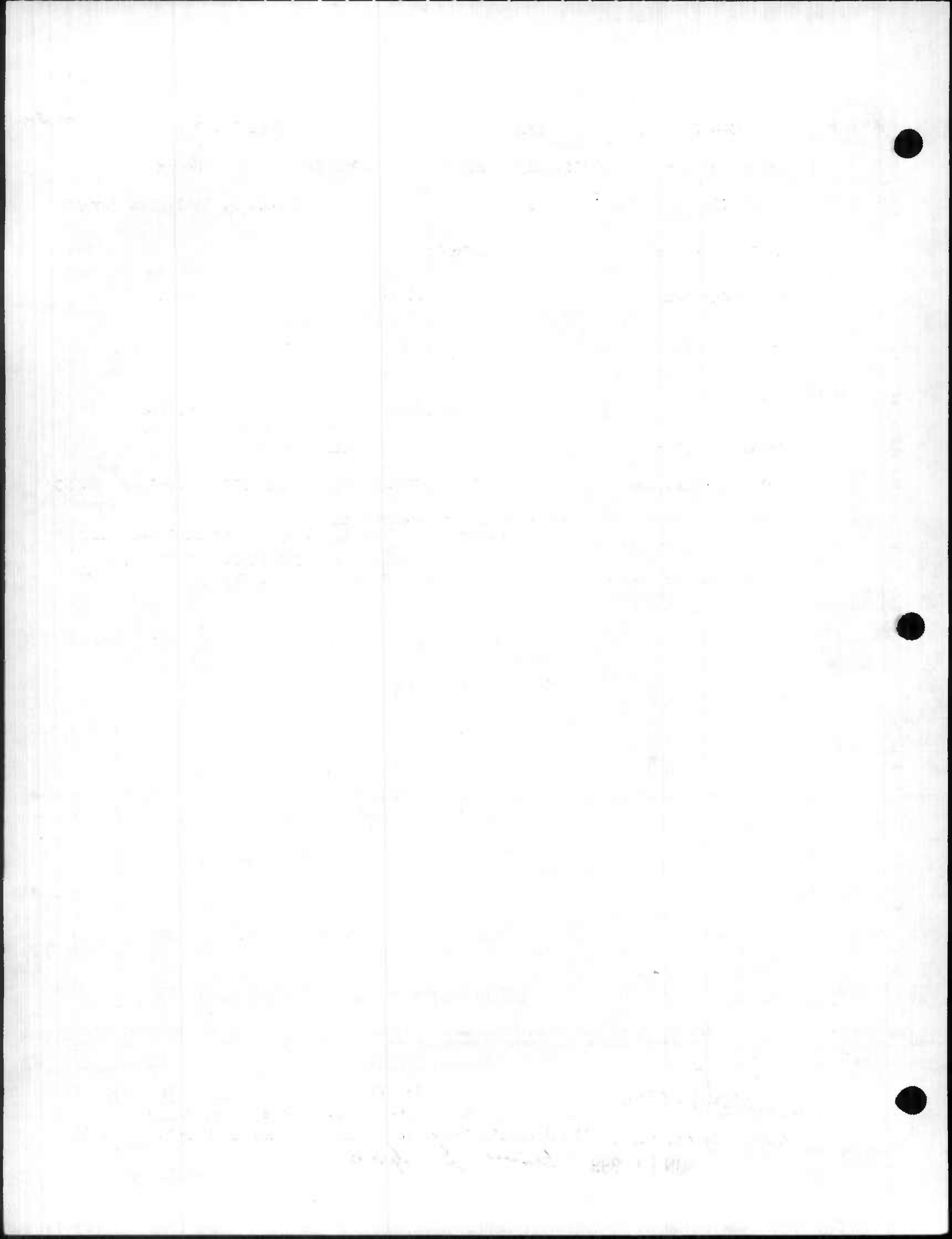
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

99 18770

DHHM 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18771

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James A. Bull				2. Date of Death Month Day Year JUNE 9, 1999		3. Time of Death 2:09 AM	
	4a. Facility Name (If not institution, give street and number) Stella Maris at Mercy Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-16-4046		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) 8-25-21	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Baltimore		10c. City, Town or Location Raspburg	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4302 Brehms Lane		10f. Zip Code 21206		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bricklayer		16b. Kind of Business/Industry Eastern Stainless St.				
17. Father's Name (First, Middle, Last) William F. Bull				18. Mother's Name (First, Middle, Maiden Surname) Lula Griffin				
19a. Informant's Name/Relationship (Type, Print) Evelyn R. Bull / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4302 Brehms Lane, Baltimore, MD 21206				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn		Date 6-11-99		20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee <i>Dennis S. Kelly</i>				22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Small Cell Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death by now				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) stella maris at mercy hospital						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Dr. [Signature]</i>				29c. License number D40854		29d. Date signed (Month, Day, Year) 6/9/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David A. Roseberg 301 St Paul Pl Baltimore 21202								
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature <i>Bernice G. Spass</i>						

To Be Completed by Funeral Director

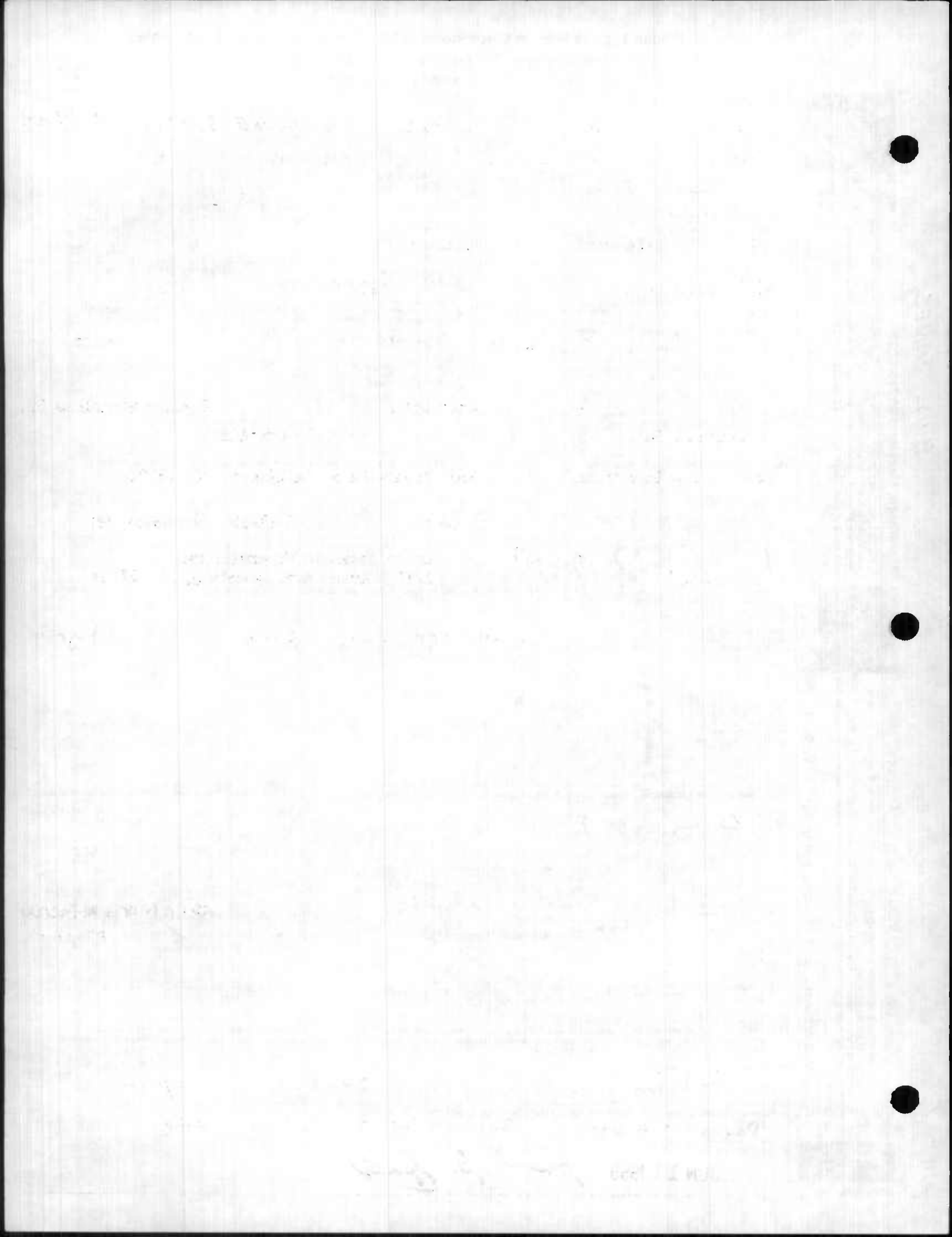
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18772

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joan Lois Brown				2. Date of Death Month Day Year June 10, 1999				3. Time of Death 5:25 AM		
	4a. Facility Name (If not institution, give street and number) St. Agnes Nursing & Rehabilitation Center				4b. City, Town, or Location of Death Ellicott City				4c. County of Death Howard		
Funeral Director	5. Social Security Number 212-30-2642		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 27, 1932		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1200 Canberwell Road				10f. Zip Code 21228				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Catonsville Community College			
17. Father's Name (First, Middle, Last) George Reid					18. Mother's Name (First, Middle, Maiden Surname) Alice Pollard						
19a. Informant's Name/Relationship (Type, Print) William Brown (Husband)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Canberwell Road, Catonsville, MD 21228						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 6/12/99		20c. Location - City or Town, State Woodlawn, Maryland				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228						
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Uro sepsis</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 1 week	
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. <u>Alzheimer's Disease</u> <u>Dementia</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 				29c. License number D34451		29d. Date signed (Month, Day, Year) 6-10-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edmund P. Skarnik 405 Frederick Rd Catonsville MD 21228											
31. Date filed (Month, Day, Year) JUN 11 1999			32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

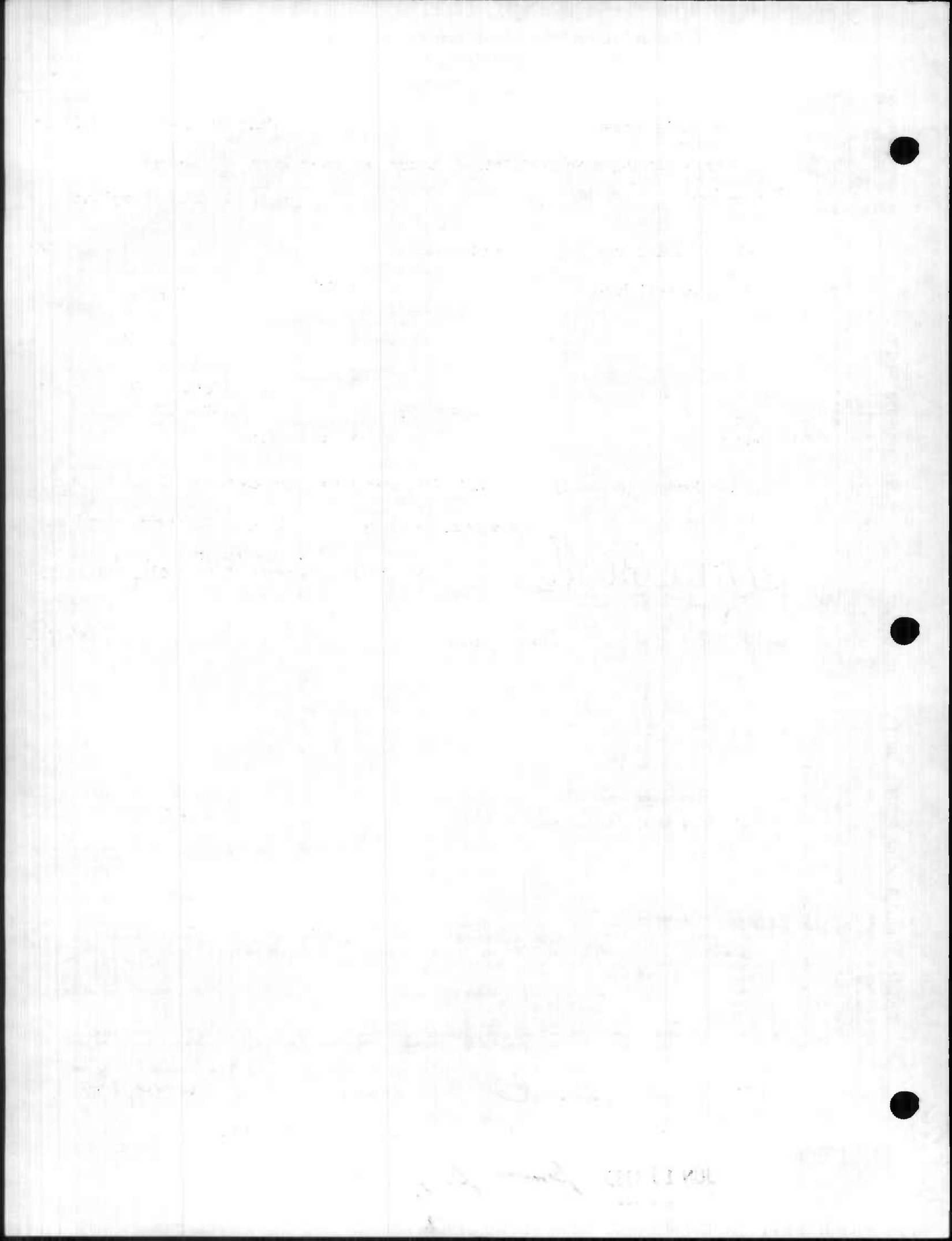
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 18773**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **EDITH BERGMAN** 2. Date of Death Month **JUNE** Day **09** Year **1999** 3. Time of Death **05:01 AM**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **Northwest Hospital Center** 4b. City, Town, or Location of Death **Randallstown** 4c. County of Death **Baltimore**

5. Social Security Number **215-22-4144** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **89** Yrs. 8. Date of Birth (Month, Day, Year) **Nov. 6, 1909** 9. Birthplace (State or Foreign Country) **NC**

Usual Residence of Decedent

10a. State **MD** 10b. County **Baltimore** 10c. City, Town or Location **Reisterstown** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **19 Brookebury Drive** 10f. Zip Code **21136** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **12** College (14 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry **Own Home**

17. Father's Name (First, Middle, Last) **David Winston Davidson** 18. Mother's Name (First, Middle, Maiden Surname) **Mary Washington LaPrade**

19a. Informant's Name/Relationship (Type, Print) **Tina J. Bergman (Daughter)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **19 Brookebury Drive, Apt 1-8, Reisterstown, MD 21136**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Loudon Park Cemetery** Date **6/11/99** 20c. Location - City or Town, State **Baltimore, Maryland**

21. Signature of Funeral Service Licensee **[Signature]** 22. Name and Address of Facility **Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Chronic Obstructive Pulmonary Disease** Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) **Chronic Obstructive Pulmonary Disease** Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last **Hypertension ; CHF ; WA** Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Hypertension ; CHF ; WA** 23b. Did tobacco use contribute to the cause of death? ☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☐ Natural ☐ Accident ☐ Suicidal ☐ Homicidal ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **[Signature] MD** 29c. License number **D44505** 29d. Date signed (Month, Day, Year) **June 9, 1999**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **A.J. IMPERIAL, JR. MD - NWHE.**

31. Date filed (Month, Day, Year) **JUN 11 1999** 32. Registrar's Signature **[Signature]**

State
Registrar

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

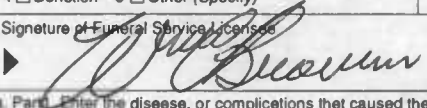
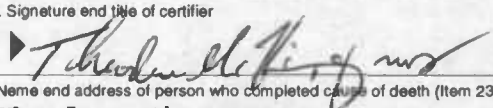
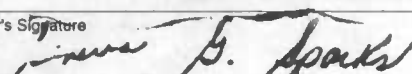
Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18774

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Devrin Sanchez Baker				2. Date of Death Month Day Year June 06, 1999		3. Time of Death 3:37 P.M.			
	4a. Facility Name (If not institution, give street and number) University of Maryland, Shock Trauma				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director	5. Social Security Number 215-98-6775		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 17 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11 18 1981		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2013 N. Bentalou Street				10f. Zip Code 21216		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry		
	17. Father's Name (First, Middle, Last) Andrew Baker				18. Mother's Name (First, Middle, Maiden Surname) Angela Smith					
	19a. Informant's Name/Relationship (Type, Print) Angela Smith/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 N. Bentalou Street, Baltimore, Md. 21216					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date 06-11-99		20c. Location - City or Town, State Baltimore, Md.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility William C. Brown Community Funeral Home 1206 W. North Avenue, Balti. Md. 21217					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 06-06-99		28b. Time of Injury 2:51 P.M.		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject was shot.	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street				28f. Location (Street and Number or Rural Route Number, City or Town, State) 1200 Block of McCulloh St., Baltimore, MD			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 10, 1999			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201									
	31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18775

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICIA ANNE CHANEL

2. Date of Death

Month Day Year
June 2 1999

3. Time of Death

~ 06:00

4a. Facility Name (If not institution, give street and number)

8852 L Spiral Cut

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

223-36-6176

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 7, 1929

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8852 L Spiral Cut

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

John B. Joynt

18. Mother's Name (First, Middle, Maiden Surname)

Mary Connelly

19a. Informant's Name/Relationship (Type, Print)

John Chanel/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11301 Georgetown Pike, Great Falls, Virginia 22066

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

6/9/99

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic mental illness (schizophrenia?)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Patricia A. Joynt, MD

29c. License number

D31473

29d. Date signed (Month, Day, Year)

June 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRYCE A. TOPE 4565 Hemlock Cove Way, Ellicott City 21042

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 11 1999

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

NO DATE

AA5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18776

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes Caravello

2. Date of Death

Month Day Year
June 9 1999

3. Time of Death

4:40 pm

4a. Facility Name (If not institution, give street and number)

Manor Care - Rossville

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-16-9458

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 29 1916

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7159 Gough St

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Rynazewski

18. Mother's Name (First, Middle, Maiden Summa)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Anthony J. Caravello Jr. /son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7159 Gough St Baltimore, MD 21224

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

June 12

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk
7110 Sollers Point Rd 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Recurrent aspiration Pneumonia

Approximate
Interval Between
Onset and Death

3 days

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation, CHF,
Type II Diabetes, Multiple CVA's

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Malika Wascem M.D.

29c. License number

D-38754

29d. Date signed (Month, Day, Year)

06-09-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASCEM. 404 EASTERN BLVD, MD-21221.

State
Registrar

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

Brenda B. Sparks

Baltimore, Maryland 21215-0020

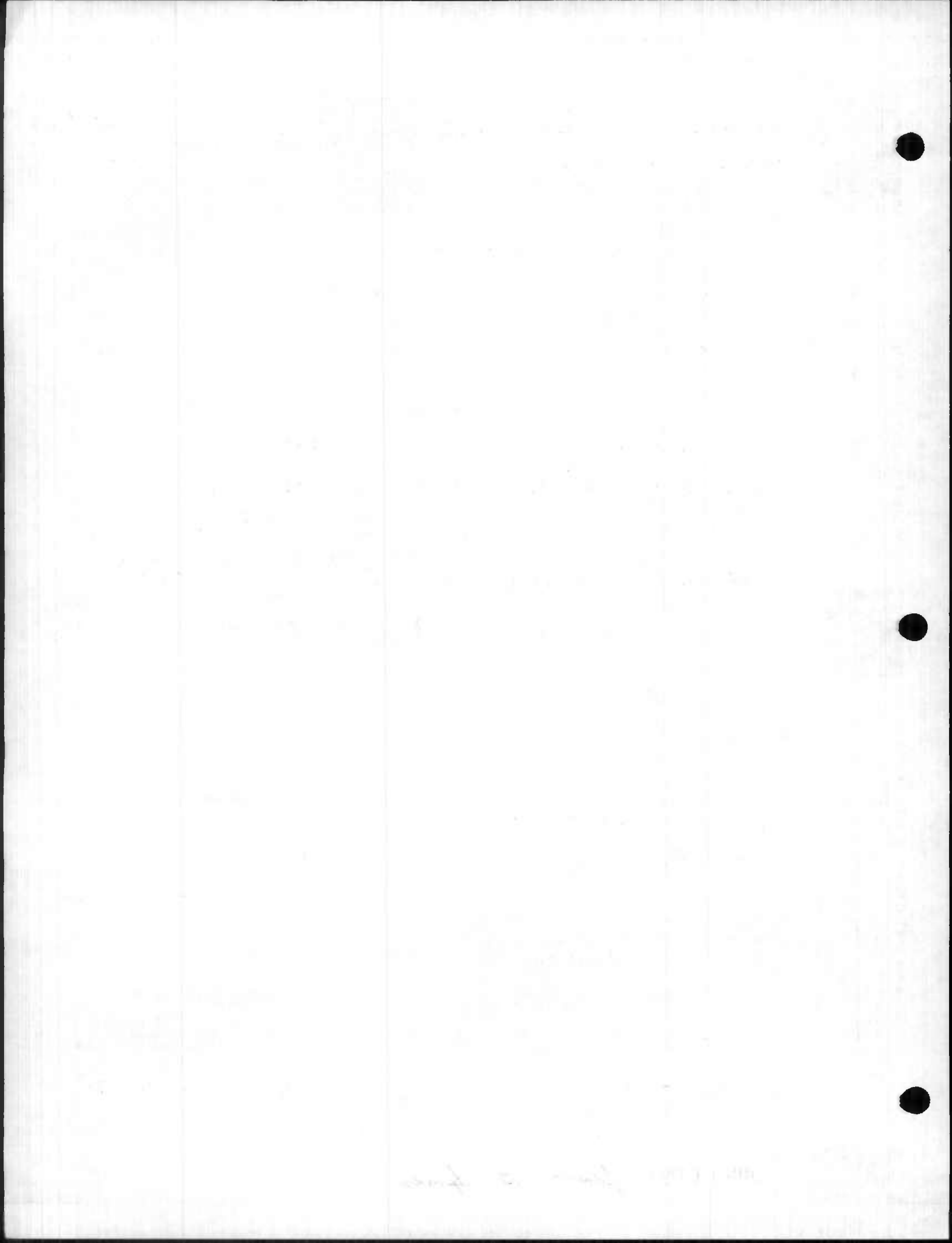
Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18777

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gilbert G Coonts

2. Date of Death

Month Day Year
June 4 1999 2:00 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

232-24-0896

6. Sex

HXM 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
02 21 1919

9. Birthplace (State or Foreign Country)

W VA

Usual Residence of Decedent

10a. State

Md

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6334 Cedar Lane

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

Jacob B. Coonts

18. Mother's Name (First, Middle, Maiden Surname)

Ruby Coonts

19a. Informant's Name/Relationship (Type, Print)

Steven Coonts/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7311 Meadow Wood Way, Clarksburg, Md 21029

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lambert Chapel Cem.

Date

0608, 1999

20c. Location - City or Town, State

Belington, W. VA

21. Signature of Funeral Service Licensee

May K. Marshall

22. Name and Address of Facility

Sterling-Ashton-Schwab Funeral Home Inc.
736 Edmondson Ave. Catonsville, Md 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Hemorrhage abdomen - acute aneurysm
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

15 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

May K. Marshall

29c. License number

021187

29d. Date signed (Month, Day, Year)

June 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Proda 1055 Little Patuxent Columbia, Maryland 21046

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

Barbara B. Spencer

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

11. *Asplenium nidus* L.

Certificate of Death

Reg. No.

99 18778

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIRGINIA T. CARTER				2. Date of Death Month Day Year JUNE 7, 1999		3. Time of Death 1230 PM						
	4a. Facility Name (If not institution, give street and number) 6203 GOLDEN RING ROAD				4b. City, Town, or Location of Death ESSEX		4c. County of Death BALTIMORE						
Funeral Director	5. Social Security Number 216-36-2742		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) MAY 29 1938		9. Birthplace (State or Foreign Country) MARYLAND				
	Usual Residence of Decedent												
10a. State MARYLAND			10b. County HARFORD CO		10c. City, Town or Location JOPPA			10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 363 BLACK BURN PLACE					10f. Zip Code 21085			10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade College (1-4 or 5+) College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRIVER			16b. Kind of Business/Industry TRANSPORTATION					
17. Father's Name (First, Middle, Last) HENRY CARTER					18. Mother's Name (First, Middle, Maiden Surname) RUTH MAE CARTER								
19a. Informant's Name/Relationship (Type, Print) Hattie M. Myers/Sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Gladway Rd, Baltimore, Maryland 21220								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY HILLS CEMETERY		Date 6-12-99		20c. Location - City or Town, State Middle River, Maryland						
21. Signature of Funeral Service Licensee <i>Barbara A. Brown</i>					22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME-HARFORDPA 321 S PHILADELPHIA BLVD ABERDEEN, MARYLAND 21001								
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Multiple Injuries</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) 6/7/99		28b. Time of Injury 11220 M		28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred Driver of bus lost control and struck fixed objects				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.			28f. Location (Street and Number or Rural Route Number, City or Town, State) Street, 6203 Golden Ring Rd, Baltimore Co, Md.										
29b. Signature and title of certifier <i>J. Pestaner M.D.</i>					29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) JUNE 8, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joseph Pestaner</i> 111 Penn Street, Baltimore, Maryland 21201													
31. Date filed (Month, Day, Year) JUN 11 1999			32. Registrar's Signature <i>James B. Sparks</i>										

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18779
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA MAE COOPER

2. Date of Death

Month

Day

Year

JUNE

7,

1999

3. Time of Death

6:34PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-68-5117

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JUL 30 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2214 DRUID HILL AVENUE

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

HOME CARE

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Diane Hudson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1611 Division St. Apt 1, Baltimore, Maryland 21217

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

METRO CREMATORY

Date

6-12-99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA

1206 W NORTH AVENUE

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small cell lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Matilda H. So...

29c. License number

D26250

29d. Date signed (Month, Day, Year)

6/8/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATILDA H. So... GBMC, 6701 N. Charles St, Baltimore, MD 21204.

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

B. Sparks

State Registrar

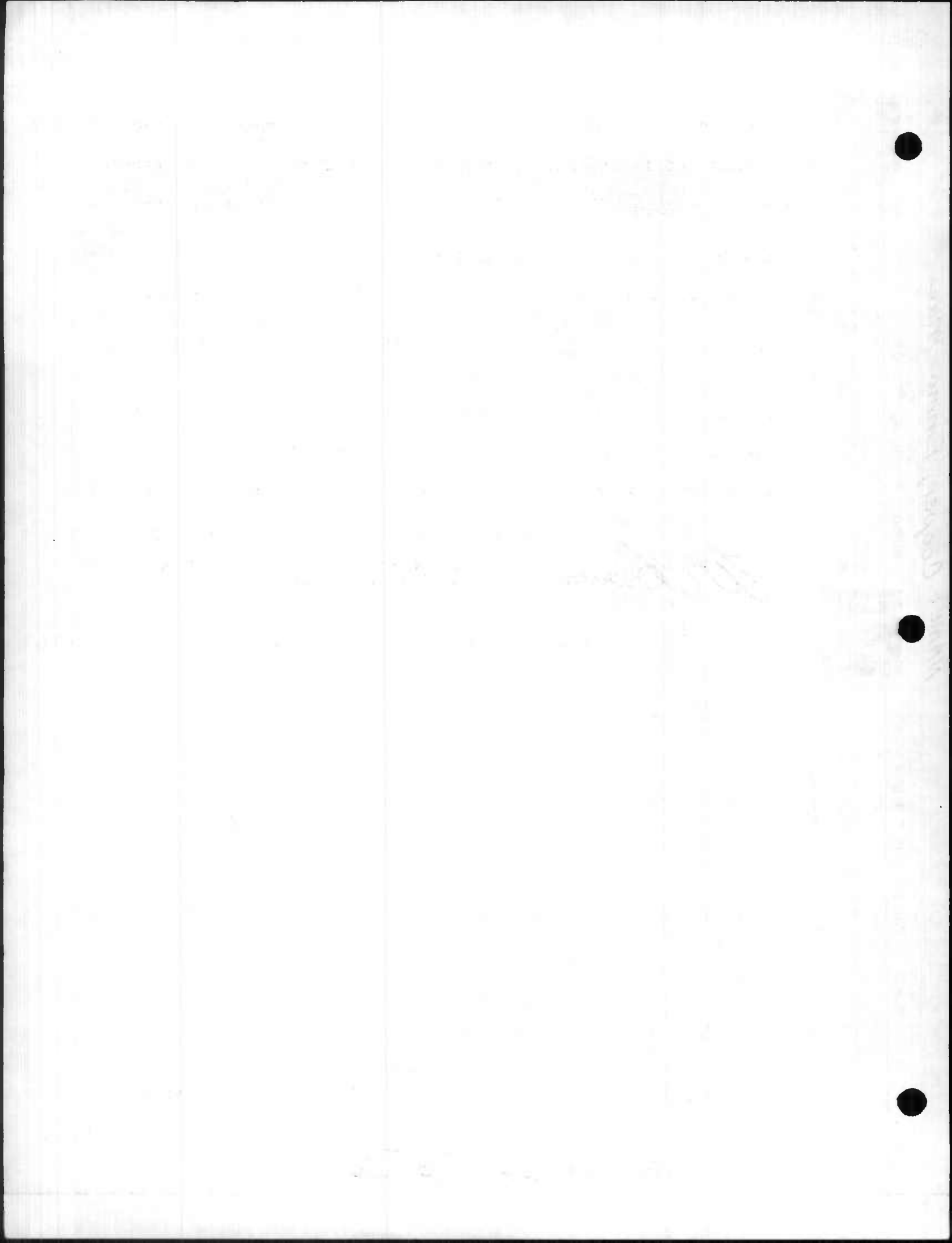
NAME: Cooper, Emma Mae
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18780

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Johnnie, Dixon, Jr.				2. Date of Death Month 06 Day 11 Year 1999		3. Time of Death 2:52 AM	
4a. Facility Name (If not institution, give street and number) Spring Grove Hosp. Center				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore County	
5. Social Security Number 578-64-192		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) APR 10, 1926	
9. Birthplace (State or Foreign Country) Virginia							
Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 55 Wade Avenue				10f. Zip Code 21228		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never Worked		16b. Kind of Business/Industry N/A	
17. Father's Name (First, Middle, Last) John Dixon, Sr.				18. Mother's Name (First, Middle, Maiden Surname) UNK.			
19a. Informant's Name/Relationship (Type, Print) Joseph Moreland/Social Worker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Wade Ave. Catonsville, MD 21228			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. Date 6/11/99		20d. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Due to (or as a consequence of): COPD Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD Atrial Fibrillation Respiratory Failure							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Shresh Shandelya				29c. License number 057239		29d. Date signed (Month, Day, Year) June 11, 1999	
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) SURESH Shandelya, Spring Grove Hospital, Wade Ave, Catonsville, MD.							
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature Beverly B. Sparks			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Johnnie Dixon, Jr.
Spring Grove Farm, Ark.
212-64-102
178

at 11 1907 20288
Carmichael
Bellevue, Ark.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18781

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Goldie Dulse

2. Date of Death

June 10 1999

3. Time of Death

1:26 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

215-22-8360

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 29, 1913

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10e. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 W. FRANKLIN street

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: african american

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing factory

17. Father's Name (First, Middle, Last)

Freeman Hines

18. Mother's Name (First, Middle, Maiden Surname)

Martha Hines

19a. Informant's Name/Relationship (Type, Print)

Tonya Roberts guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

34 Market Place Suite 300 Balto. MD 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Star

Date

6/14/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Albert P. Wylie F/H PA
638 N. Gilmor St Baltimore MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. coronary artery disease

Approximate Interval Between Onset and Death

unknown

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

150643742

29d. Date signed (Month, Day, Year)

June 10, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Brian E. Enrie, MD 414 W Redwood St, Suite 280 Baltimore, MD

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The few requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18782

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phillip E. Daniels				2. Date of Death Month Day Year June 09 1999		3. Time of Death 22:06	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death NA	
Funeral Director	5. Social Security Number 212-50-5726	6. Sex M	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MARCH 27, 1950		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County NA		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 1021 WEBB COURT				10f. Zip Code 21202		10g. Citizen of What Country? USA		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PORTER			16b. Kind of Business/Industry NURSING HOME	
17. Father's Name (First, Middle, Last) ROBERT N. DANIELS				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH DANIELS				
19a. Informant's Name/Relationship (Type, Print) FRIEND BARBARA J. FRANKLIN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1021 WEBB COURT BALTIMORE, MD 21202				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEM		20c. Location - City or Town, State APRIL 15/99 BALTIMORE, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ALBERT P. WYLLIE F/H PA 638 N. GILMORE ST BALTIMORE MD 21217				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e. hepatic failure Due to (or as a consequence of):								24 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. cirrhosis Due to (or as a consequence of):								years
c. hepatitis C Due to (or as a consequence of):								years
d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
								24a. Was an autopsy performed? 1 Yes 2 No
								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number RES-000		29d. Date signed (Month, Day, Year) June 09, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Taylor A. Sohn MD, Johns Hopkins Hospital; 600 N. Wolfe St, Baltimore MD								
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18783

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS DELLA

2. Date of Death

Month Day Year

JUNE 8, 1999

3. Time of Death

7:58PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-16-3028 A

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCT. 17, 1914

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1308 N. WASHINGTON STREET

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify AFRO-AMERICAN

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSEWORK

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

JUDGE FOWLKES

18. Mother's Name (First, Middle, Maiden Summa)

LELIA DASWELL

19a. Informant's Name/Relationship (Type, Print)

DOROTHY FOWLKES / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4111 SHANNON DRIVE BALTO, MD. 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

JUNE 15, 1999

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee

Calvin B. Scruggs

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO, MD.

21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. CARDIAC ARREST
Due to (or as a consequence of):b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C.O.P.D.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending
investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D15634

29d. Date signed (Month, Day, Year)

6-10-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. K. KALACHANDAN MD 3411 Rand Road Beltsville MD 20724

State
Registrar

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18784

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) <u>Leland Dukes</u>				2. Date of Death Month <u>6</u> Day <u>7</u> Year <u>99</u>		3. Time of Death <u>01:15</u>	
4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>Baltimore City</u>	
5. Social Security Number <u>247-42-7261</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>68</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>06 17 1930</u>	
				If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
9. Birthplace (State or Foreign Country) <u>SC</u>							

Usual Residence of Decedent			
10a. State <u>Md</u>	10b. County <u>N/A</u>	10c. City, Town or Location <u>Baltimore</u>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

10e. Street and Number <u>1612 North Bentalou Street</u>	10f. Zip Code <u>21216</u>	10g. Citizen of What Country? <u>USA</u>
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11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>
--	---	--	---

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>3</u> College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Machine Operator</u>	16b. Kind of Business/Industry <u>Lumber Yard</u>
---	--	--

17. Father's Name (First, Middle, Last) <u>Peter Dukes, Sr.</u>	18. Mother's Name (First, Middle, Maiden Surname) <u>Susie Mae Hilton</u>
--	--

19a. Informant's Name/Relationship (Type, Print) <u>Shirley Dukes/Daughter</u>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1612 North Bentalou Street, Balto, Md. 21216</u>
---	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Whack Cemetery</u>	Date <u>6/11/99</u>	20c. Location - City or Town, State <u>Greeleyville, SC</u>
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21. Signature of Funeral Service Licensee <u>Mark Marshall</u>	22. Name and Address of Facility <u>Sterling-Ashton-Schwab Funeral Home, Inc</u> <u>736 Edmondson Avenue, Balto, Md. 21228</u>
---	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death)	a. <u>Pneumonia</u> Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>Metastatic Prostate Carcinoma</u> Due to (or as a consequence of):	
	c. _____ Due to (or as a consequence of):	
	d. _____ Due to (or as a consequence of):	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
--	--

24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
---	--

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <u>M</u>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
--

29b. Signature and title of certifier <u>[Signature] MD</u>	29c. License number <u>P11216</u>	29d. Date signed (Month, Day, Year) <u>6/7/99</u>
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>22 S. Greene St Baltimore MD 21202, Michael Banks</u>
--

31. Date filed (Month, Day, Year) <u>JUN 11 1999</u>	32. Registrar's Signature <u>[Signature]</u>
---	---

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AK5

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text, likely bleed-through from the reverse side of the page]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18785

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Elizabeth Daneker					2. Date of Death Month Day Year June 3, 1999		3. Time of Death 9:30pm		
	4a. Facility Name (If not institution, give street and number) Box 1100 Gumbottom Road					4b. City, Town, or Location of Death Crownsville		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 216-12-6372		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 11, 1919		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent									
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Crownsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number Box 1100 Gumbottom Road					10f. Zip Code 21032		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Albert Earl Irving					18. Mother's Name (First, Middle, Maiden Surname) Edna R. Robinson					
19a. Informant's Name/Relationship (Type, Print) James Dameron Daneker-Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 1107 Gumbottom Road, Crownsville, MD 21032					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Baldwin Memorial Cem.		Date 6/8		20c. Location - City or Town, State Millersville, MD			
21. Signature of Funeral Service Licensee <i>Batrick A. ...</i>					22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Metastatic cancer - site unknown</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 Yr
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Breast cancer</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Joseph M. Friend</i>					29c. License number D17965		29d. Date signed (Month, Day, Year) 6/8/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joseph M. Friend 205 Ridgely Ave Annapolis, Md 21401</i>										
31. Date filed (Month, Day, Year) JUN 11 1999					32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18786

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Marie Duncan				2. Date of Death Month Day Year June 7, 1999				3. Time of Death 3:15am	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 234-22-4224		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74		8. Date of Birth (Month, Day, Year) Nov. 2, 1924		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 9 Barbara Dale Lane				10f. Zip Code 21401		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier			16b. Kind of Business/Industry Retail Food		
	17. Father's Name (First, Middle, Last) George W. Duncan				18. Mother's Name (First, Middle, Maiden Surname) Mary Mayse					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kandy Rae Larkin - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Barbara Dale Lane, Annapolis, MD 21401					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 6/8		20c. Location - City or Town, State Baltimore, MD			
	21. Signature of Funeral Service Licensee <i>Kendall S. Rowe</i>				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intestinal Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Acute									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Shock, Acidosis							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>R. Bokhari</i>		29c. License number D-26594		29d. Date signed (Month, Day, Year) 6/7/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Bokhari Anne Arundel Medical Center, Annapolis MD 21401										
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature <i>B. Sparks</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMENDED ITEM #5 PER FH G772 6/25/99 AH

99 18787

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) <i>Mary Fergus</i>				2. Date of Death Month <i>June</i> Day <i>02</i> Year <i>1999</i>		3. Time of Death <i>0025</i>	
4a. Facility Name (If not institution, give street and number) <i>Liberty Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
5. Social Security Number <i>212-204996</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>56</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month <i>DEC</i> Day <i>14</i> Year <i>1942</i>	
9. Birthplace (State or Foreign Country) <i>VIRGINIA</i>							
10a. State <i>MD.</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>2002 BRYANT AVENUE</i>				10f. Zip Code <i>21217</i>		10g. Citizen of What Country? <i>U.S. OF A.</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>UNKNOWN</i> College (1-4 or 5+) <i>UNKNOWN</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>SECRETARY</i>		16b. Kind of Business/Industry <i>BAIL BOND</i>	
17. Father's Name (First, Middle, Last) <i>JAMES FIELDS</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>LOUISE PITTS FIELDS</i>			
19a. Informant's Name/Relationship (Type, Print) <i>LOUISE FIELDS (MOTHER)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2002 BRYANT AVE. BALTIMORE.MD. 21217</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>DRUID RIDGE CEM. 6/7/99</i>		Data		20c. Location - City or Town, State <i>BALTO PIKESVILLE, MD. Co.</i>	
21. Signature of Funeral Service Licensee <i>Lewis T. Gwynn</i>				22. Name and Address of Facility <i>LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO..MD.</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. CORONARY ARTERY DISEASE</i> Due to (or as a consequence of): <i>b. HYPERTENSION</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Edward Bogian</i>				29c. License number <i>D31993</i>		29d. Date signed (Month, Day, Year) <i>June 10, 1999</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Liberty Medical Ctr, 2000 Liberty Hgts. Ave Balt. Md.</i>							
31. Date filed (Month, Day, Year) <i>JUN 11 1999</i>				32. Registrar's Signature <i>B. Sparks</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

131-132-133

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18788

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Francis J. Feldmann, Jr.				2. Date of Death Month: June Day: 9 Year: 1999		3. Time of Death 1:25 PM	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-48-7619		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 28, 1943	
	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 802 Wellington Rd.				10f. Zip Code 21212		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (14 or 5+): 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Price Analyst		16b. Kind of Business/Industry Department of Defense			
	17. Father's Name (First, Middle, Last) Francis J. Feldmann, Sr.				18. Mother's Name (First, Middle, Maiden Surname) M. Shirley Herzer			
	19a. Informant's Name/Relationship (Type, Print) (sister) Mrs. Mary Jane Feldmann Cook				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8228 Burnley Rd. Towson, Md. 21204			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Location - City or Town, State 6/14/99 Baltimore, Md.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pulmonary embolus Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last history recurrent + deep venous thrombi Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. history recurrent + deep venous thrombi						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number RES 000		29d. Date signed (Month, Day, Year) 6/9/1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dana Cummings MD PhD Johns Hopkins Hospital							
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18789

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Fincham				2. Date of Death Month Day Year June 8, 1999				3. Time of Death 11:45 PM	
	4a. Facility Name (If not institution, give street and number) Robosson Court Nursing Center				4b. City, Town, or Location of Death Randallstown				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-22-9653		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) 04-22-1928		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Delaware		10b. County Sussex		10c. City, Town or Location Lewes				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number MC 25 Tall Pines				10f. Zip Code 19958		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1946-1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (14 or 5+) -----				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic			16b. Kind of Business/Industry Shell Station		
	17. Father's Name (First, Middle, Last) Oscar Fincham				18. Mother's Name (First, Middle, Maiden Surname) Annie Carey					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Irene A. Fincham (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MC 25 Tall Pines Lewes, DE 19958					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Balt. Wash. Crematory		20c. Location - City or Town, State 6-14-99 Laurel, Maryland			
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Severe Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease Seizure Disorder									
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier				29c. License number 029085				29d. Date signed (Month, Day, Year) June 9 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen J. Chincus MD 5310 Old Court Road 21133									
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature B. Sparks								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18790

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph Winfred Finney, Sr.

2. Date of Death

Month
JuneDay
8,Year
1999

3. Time of Death

5:35 AM

4a. Facility Name (If not institution, give street and number)

4409 Belvieu Ave.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

215-14-0678

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

09-13-1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4409 Belvieu Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1946-

1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

4 Years

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Social Security

Administration

17. Father's Name (First, Middle, Last)

James C. Finney

18. Mother's Name (First, Middle, Maiden Surname)

Edna L. Waters

19e. Informant's Name/Relationship (Type, Print)

Gertrud E. Finney (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4409 Belvieu Ave. Baltimore, Maryland 21215

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

6-14-99

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, Maryland 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Colon cancer

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (from 23e) (Type, Print)

W. A. Riley & BMC 6701 N. Charles St. Balto. Md 21208

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 11 1999

J. A. Spence

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

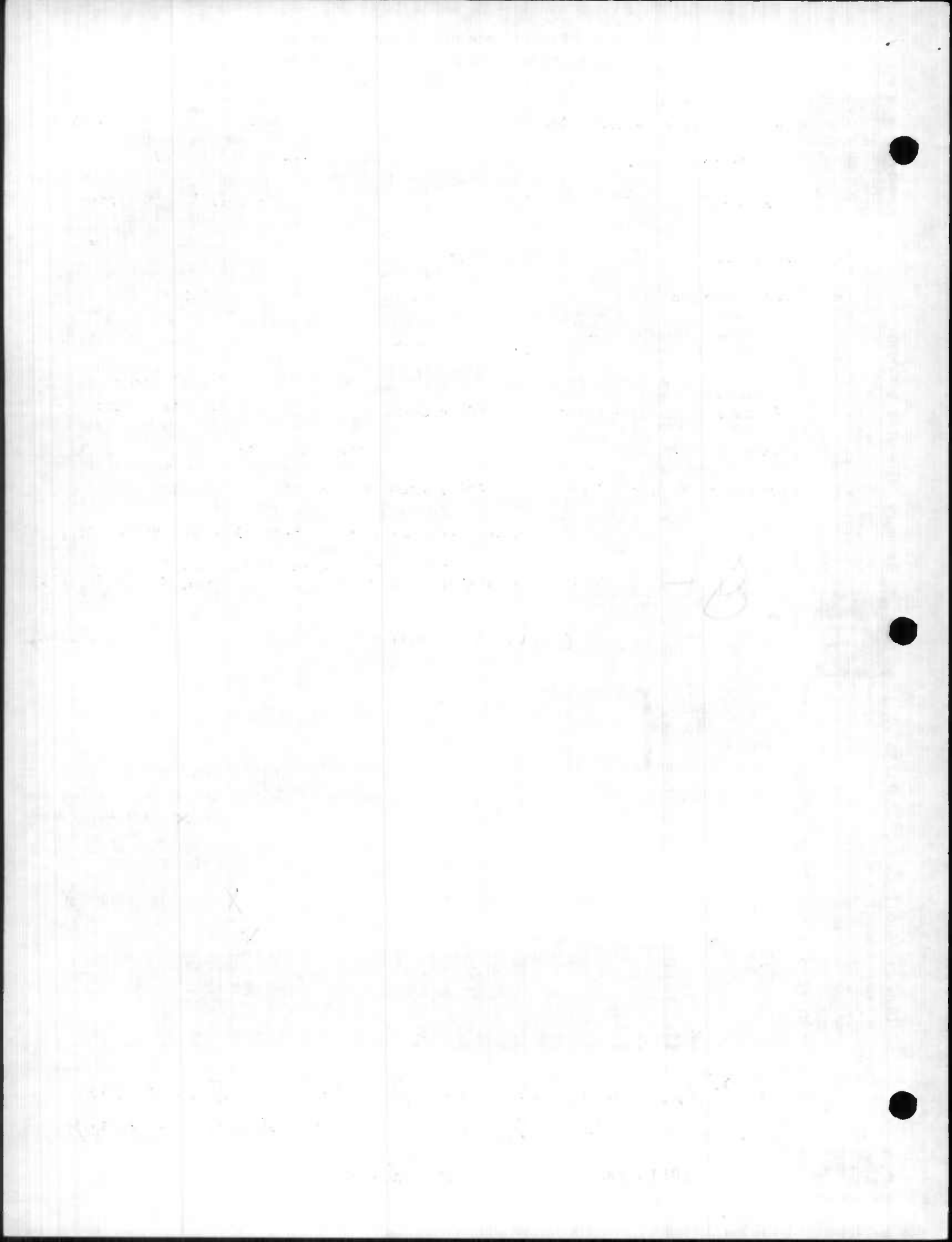
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18792

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <u>Carroll Gamber</u>				2. Date of Death Month Day Year <u>June 10, 1999</u>		3. Time of Death <u>6:00am</u>	
4a. Facility Name (If not institution, give street and number) <u>St. Agnes Nursing & Rehabilitation Center</u>				4b. City, Town, or Location of Death <u>Ellicott City</u>		4c. County of Death <u>Howard</u>	
5. Social Security Number <u>213-09-6152</u>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>82</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Aug. 22, 1916</u>	
9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Catonsville</u>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <u>111 Garden Ridge Road</u>		10f. Zip Code <u>21228</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Maintenance Mechanic</u>		16b. Kind of Business/Industry <u>Funeral Home</u>			
17. Father's Name (First, Middle, Last) <u>Henry J. Gamber</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Sally A. Lilly</u>			
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Crestlawn</u>		20c. Date <u>6/14/99</u>		20d. Location - City or Town, State <u>Marriottsville, MD</u>	
21. Signature of Funeral Service Licensee <u>Richard L. Witzke</u>				22. Name and Address of Facility <u>Witzke Funeral Homes, Inc.</u> <u>1630 Edmondson Avenue, Catonsville, MD 21228</u>			

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Terminal lung carcinoma</u> Due to (or as a consequence of): b. <u>Smoking</u> Due to (or as a consequence of): c. <u></u> Due to (or as a consequence of): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <u>1 year</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>[Signature]</u> <u>MD</u>		29c. License number <u>D35309</u>	
29d. Date signed (Month, Day, Year) <u>6/10/99</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Sandra Sattin 2850 N Ridge Rd Ellicott City MD 21043</u>			
31. Date filed (Month, Day, Year) <u>JUN 11 1999</u>		32. Registrar's Signature <u>[Signature]</u>			

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

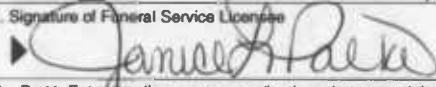
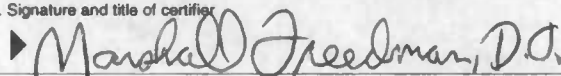
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18791

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM GORDON						2. Date of Death Month Day Year JUNE 8 1999		3. Time of Death 12:08 PM	
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital						4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 579-44-6962		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) June 27, 1934		9. Birthplace (State or Foreign Country) Unknown	
	Usual Residence of Decedent									
10a. State MD		10b. County Howard		10c. City, Town or Location Savage				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 8536 Storch Wood Drive #1-A						10f. Zip Code 20763		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed			16b. Kind of Business/Industry Never Worked			
17. Father's Name (First, Middle, Last) Unavailable						18. Mother's Name (First, Middle, Maiden Surname) Unavailable				
19a. Informant's Name/Relationship (Type, Print) Betty Balazs/Friend						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6301 Forest mill Lane, Laurel, Maryland 20707				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Prk			Date 6/14		20c. Location - City or Town, State Elkridge, Maryland		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pharyngeal Carcinoma Due to (or as a consequence of): a. b. c. d. Approximate Interval Between Onset and Death 1 year										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 						29c. License number H37211		29d. Date signed (Month, Day, Year) JUNE 8, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshall Freedman, D.O. 2 KNOLL N. COLUMBIA, MD 21045										
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18793

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Samuel G. Godfrey, Jr.		2. Date of Death Month Day Year June fifth 1999		3. Time of Death 3:40 AM
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital Oncology 2		4b. City, Town, or Location of Death Baltimore		4c. County of Death
Funeral Director	5. Social Security Number 191-01-5193	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 78	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 01-14-1921		9. Birthplace (State or Foreign Country) Evanstown, PA		
To Be Completed by Funeral Director	10e. State PA		10b. County Westmoreland		10c. City, Town or Location Luxor
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 128 Old School Road.		10f. Zip Code 15662		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. White		Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Quality Control		16b. Kind of Business/Industry Dept. of Defense
	17. Father's Name (First, Middle, Last) Samuel G. Godfrey, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Elvin McMahon		
	19a. Informant's Name/Relationship (Type, Print) Elizabeth Godfrey- Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Old School Rd. Luxor, PA 15662		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greensburg Catholic		Date 6/9/99
	20c. Location - City or Town, State Greensburg, PA				
Physician /Medical Examiner	21. Signature of Funeral Service Licensee M. K. Marshall		22. Name and Address of Facility Sterling Ashton-Schwab Funeral Home Inc. 736 Edmondson Ave. Catonsville, Md 21228		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. Hypotension Due to (or as a consequence of):				6 hours
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. sepsis Due to (or as a consequence of):				2 days
	c. Myelodysplastic syndrome Due to (or as a consequence of):				10 years
	d.				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Ella Evron MD		29c. License number D0054145		29d. Date signed (Month, Day, Year) June sixth 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ella Evron Johns Hopkins oncology center 600 N Wolfe st. Baltimore MD 21287					
State Registrar	31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature B. Sparks		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

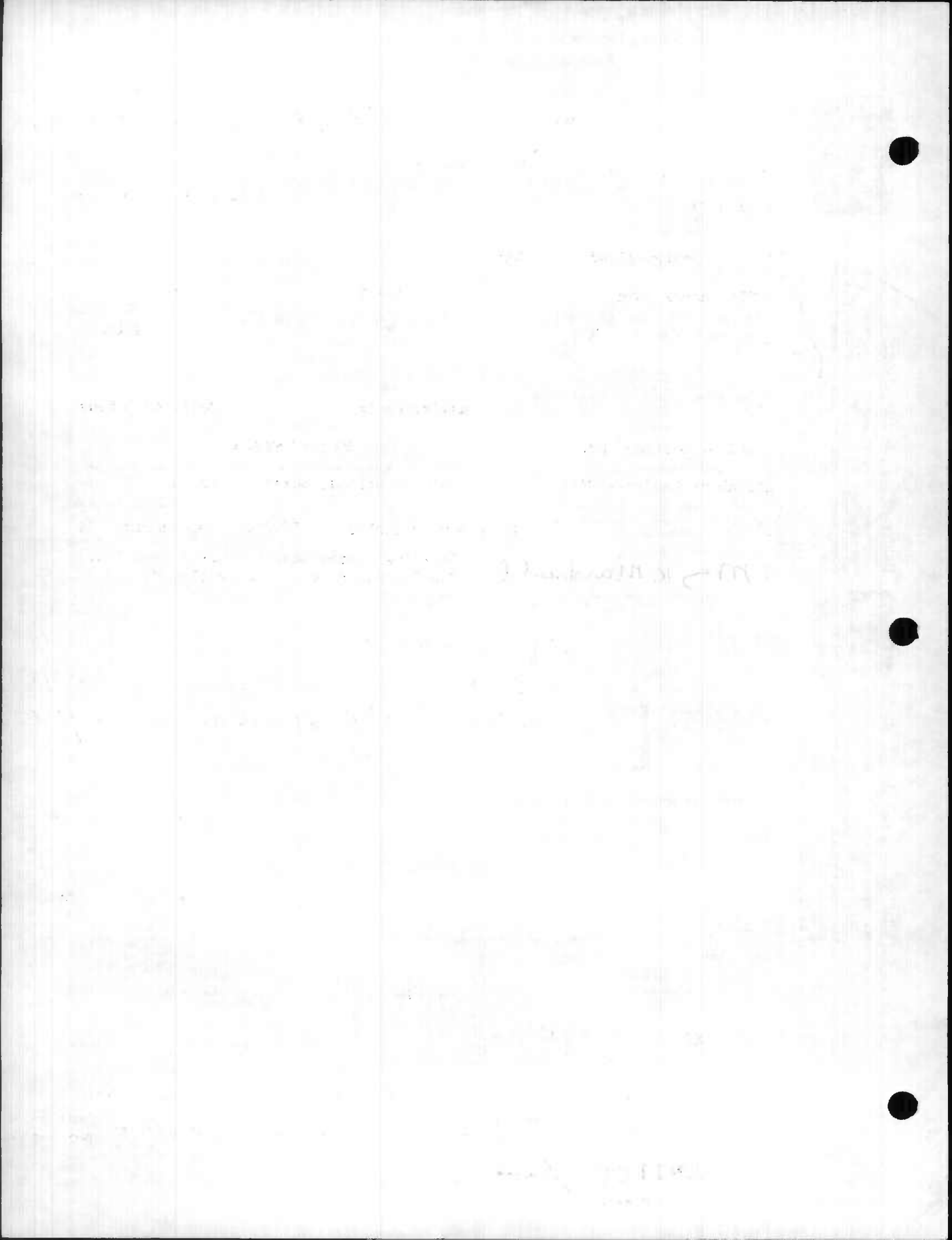
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18794

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Gagliardi

2. Date of Death

Month
JuneDay
9Year
1999

3. Time of Death

12:30 A.M.

4a. Facility Name (If not institution, give street and number)

Millennium Health & Rehabilitation Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

215 24 6730

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year
June 21, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5818 Redmond Street

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9th

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Top Secret

16b. Kind of Business/Industry

Westinghouse

17. Father's Name (First, Middle, Last)

Arthur R. Tilghman

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Apple

19a. Informant's Name/Relationship (Type, Print)

Janice Henson / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

462 Seward Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glen Haven Memorial Park

Date

6/12/99

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

RESPIRATORY FAILURE
Due to (or as a consequence of):

5 DAYS

b.

PNEUMONIA
Due to (or as a consequence of):

5 DAYS

c.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- GENERALIZED ARTERIOSCLEROSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

J. L. Luby M.D.

D-22609

JUNE 9, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBEN REIDEN M.D. 7445 FURNACE BRANCH Rd Glen Burnie Md 21060

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18795

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

FRANCES A GERHARDT

2. Date of Death
Month Day Year

JUNE 8 1999

3. Time of Death

3:41 PM

4a. Facility Name (If not institution, give street and number)

HARSHAL HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

215 30 2301

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 12, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

314 Phelps Avenue

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Reconcile Clerk

16b. Kind of Business/Industry

Federal Reserved Bank

17. Father's Name (First, Middle, Last)

Frank Grodzicki

18. Mother's Name (First, Middle, Maiden Surname)

Grace C. Kimball

19a. Informant's Name/Relationship (Type, Print)

Daniel Gerhardt / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

314 Phelps Avenue Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

6/11/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Richard E. Davis

22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ADULT RESPIRATORY DISTRESS SYNDROME

Due to (or as a consequence of):

2 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CAPILLARY LEAK DYNDROME

Due to (or as a consequence of):

DAYS

c. HYPOALBUMINEMIA

Due to (or as a consequence of):

WEEKS

d. MALNUTRITION

WEEKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

CHRONIC PANCREATITIS

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Gerard M. Lowder MD

29c. License number

D29296

29d. Date signed (Month, Day, Year)

JUNE 8, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GERARD M LOWDER

901 EAST FORT AVENUE

BALTIMORE MD 21230

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

Gerard M. Lowder

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Project Title: [Illegible]

Author: [Illegible]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18796

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hugh Graham				2. Date of Death Month 06 Day 08 Year 1999		3. Time of Death 2:30 a.m.	
	4a. Facility Name (If not institution, give street and number) Joseph Ritchie Hospice				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-26-7196	6. Sex XX M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-29-1931		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 123 W. 29th Street				10f. Zip Code 21218		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roofer		16b. Kind of Business/Industry Roofing Company		
17. Father's Name (First, Middle, Last) Hugh Graham				18. Mother's Name (First, Middle, Maiden Surname) Minnie Dingle				
19a. Informant's Name/Relationship (Type, Print) Rev. Billy Graham/brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Troon Circle, Mt. Airym Maryland 21771				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro		Date 6/11/99		20c. Location - City or Town, State Catonsville, Md.
21. Signature of Funeral Service Licensee <i>Charles H. Powell</i>				22. Name and Address of Facility Charles H. Powell Funeral Services 1206 W. North Avenue, Baltimore, Md. 21211				
23a. Part I. Enter the disease, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Carcinoma Lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 yrs				Approximate Interval Between Onset and Death 2 yrs				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Negice				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Robert C. Irwin MD</i>		29c. License number DO8900		29d. Date signed (Month, Day, Year) 6-8-99
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert C. Irwin MD 808 N. Eutaw St. Baltimore Md 21201								
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature <i>B. Sparks</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #26 PER MD G772 6-11-99WR.

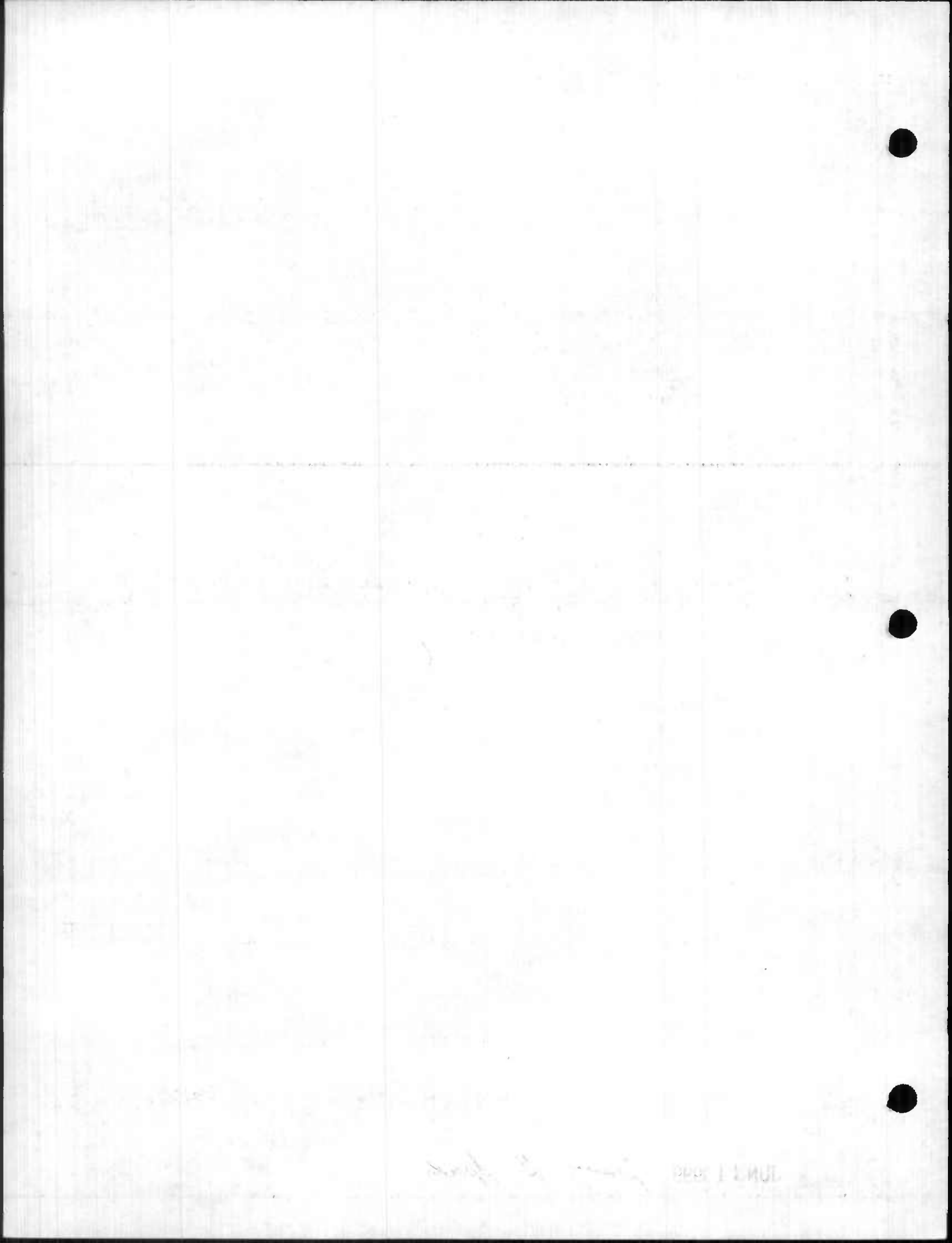
Certificate of Death

Reg. No. 99 18797

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph T. Hargrave				2. Date of Death Month 6 Day 6 Year 1999		3. Time of Death 4: pm	
	4a. Facility Name (If not institution, give street and number) 5500 Frankford Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 242-36-2690		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) 8-16-1930	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) N.C.		10. State MD		10b. County NA	
To Be Completed by Funeral Director	10a. Street and Number 401 E. 25th Street		10f. Zip Code 21218		10g. Citizen of What Country? U.S.A		10c. City, Town or Location Baltimore	
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Officer		16b. Kind of Business/Industry Manekin Corp	
	17. Father's Name (First, Middle, Last) Frank Lewis Hargrave				18. Mother's Name (First, Middle, Maiden Surname) Jennett Partee			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jeanette Crosier - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5500 Frankford Avenue Baltimore, Md 21206			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet		20c. Location - City or Town, State 6-11-99 Owings Mills, Md		20d. Date 21215	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility March F.H. West 4300 Wabash Avenue Baltimore, Md			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pancreatic Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 8/98			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) DAUGHTER'S HOUSE					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Joseph G. Zangara M.D.				29c. License number D-50917		29d. Date signed (Month, Day, Year) 06/09/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH GREENE ST. Rm N3W62 BALTIMORE, MD 21201							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature [Signature]			
	State Registrar							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



[Faint, illegible handwriting]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18798

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLOTTE HARDY				2. Date of Death Month MAY Day 31 Year 1999		3. Time of Death 1455		
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director	5. Social Security Number 214-34-2552		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) 10 6 38		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3612 Eldorado Ave. # 3A		10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Greenes Scott Key Medical		17. Father's Name (First, Middle, Last) Joseph Greene		18. Mother's Name (First, Middle, Maiden Surname) Beala Green		19a. Informant's Name/Relationship (Type, Print) Diane McBride - Daughter	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 N. Wolfe St. Balto. Md. 21205		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State 611. 99 Balto. Md.		21. Signature of Funeral Service Licensee Jeff Miller	
22. Name and Address of Facility Jeff Miller P.C. Funeral Home & Services 1659 N. Broadway Balto. Md. 21213		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. gastrointestinal Due to (or as a consequence of): b. cirrhosis Due to (or as a consequence of): c. alcoholism Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 1 day 1 year 20 Years		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Were an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Ross Summer MD		29c. License number RES000		29d. Date signed (Month, Day, Year) MAY 31 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ross Summer 600 North Wolfe Street Baltimore Maryland	
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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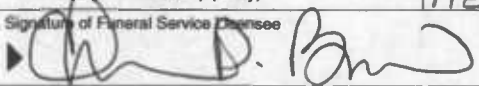
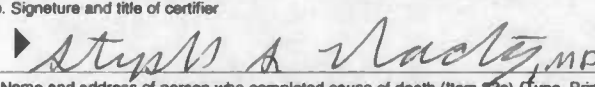

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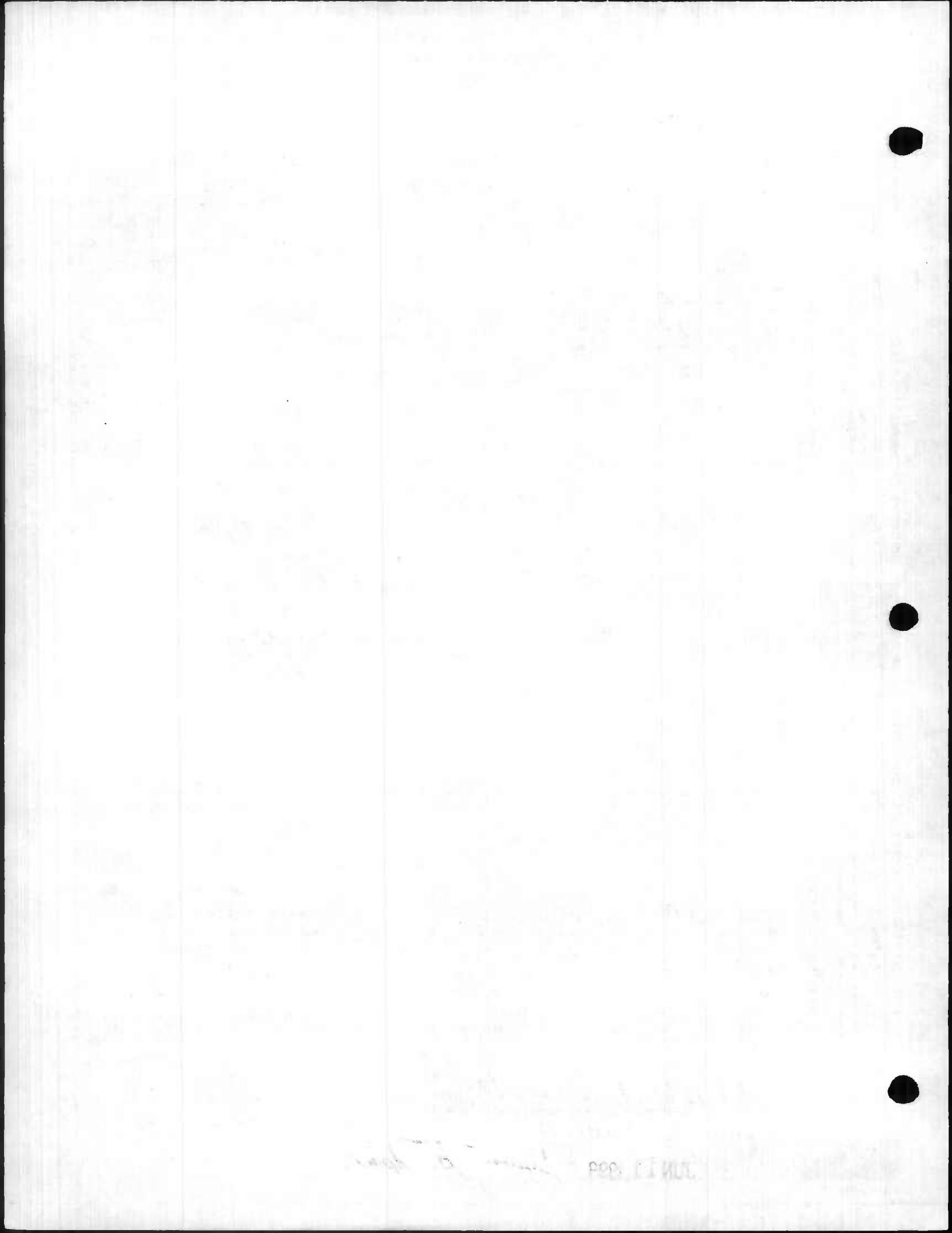
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18799

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SCOTT WARREN HAWKINS				2. Date of Death Month Day Year June 09, 1999		3. Time of Death 11:12 A.M.			
	4a. Facility Name (If not institution, give street and number) University of Maryland, Shock Trauma				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director	5. Social Security Number 213-80-7067		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 33 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MARCH 27, 1966	9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 4313 DANA STREET				10f. Zip Code 21229		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) 2 YRS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER			16b. Kind of Business/Industry U.S. POSTAL SERVICE				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) WARREN RHODES				18. Mother's Name (First, Middle, Maiden Surname) CYNTHIA HAWKINS					
	19a. Informant's Name/Relationship (Type, Print) LYDIA HAWKINS (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4313 DANA STREET BALTIMORE, MD. 21229					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Location - City or Town, State 06-15-99 BALTIMORE, MARYLAND					
	21. Signature of Funeral Service Director 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217							
Physician /Medical Examiner	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Two gunshot wounds to the chest and left leg with complications Due to (or as a consequence of):							Approximate Interval Between Onset and Death		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 5-30-99		28b. Time of Injury 0115 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject was shot	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 10, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201									
State Registrar	31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature 					



Handwritten signature or initials.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18800

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY P HUGHES				2. Date of Death Month JUNE Day 8 Year 1999		3. Time of Death 12:52 PM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 227-11-6794		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 5 1961	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD.		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 5408 Hamlet Ave.		10f. Zip Code 21214		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Musician		16b. Kind of Business/Industry Music			
	17. Father's Name (First, Middle, Last) Joseph Matthew Hughes				18. Mother's Name (First, Middle, Maiden Surname) Doris Laughlin			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Joseph M. Hughes/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10809 Ann St. Fairfax City, VA. 22030			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Date 6-12-99		20d. Location - City or Town, State Baltimore, MD.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS SYNDROME Due to (or as a consequence of): b. BILATERAL PNEUMONIA Due to (or as a consequence of): c. GRAFT VERSUS HOST DISEASE Due to (or as a consequence of): d. RENAL FAILURE AND GI BLEEDING							Approximate Interval Between Onset and Death 2 DAYS 1 WEEK 10 DAYS 1.5 MONTHS
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STATUS POST MATCHED UNRELATED BMT FOR MDS/AML							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Gorgun Akpek M.D. Fellow				29c. License number RES-000		29d. Date signed (Month, Day, Year) 6/8/1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GORGUN AKPEK, M.D., JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND 21287							
State Registrar	31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 					

[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. Some words like "STATION" and "X" are visible.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

18801

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA MARIE IORIO				2. Date of Death Month Day Year JUNE 8, 1999		3. Time of Death 2107	
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 072-28-6690		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 14, 1935	9. Birthplace (State or Foreign Country) NEW YORK
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 7765 OVERHILL ROAD				10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) VINCENT D'ANGELO					18. Mother's Name (First, Middle, Maiden Surname) LUCIA GENIALE			
19a. Informant's Name/Relationship (Type, Print) JOHN J. IORIO, JR. (SON)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1941 CEDAR ROAD, PASADENA, MARYLAND 21122			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERANS CEMETERY		Date 6/11/99		20c. Location - City or Town, State CROWNSVILLE, MD.	
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Venous thrombo embolic disease Due to (or as a consequence of): b. congestive heart failure Due to (or as a consequence of): c. End stage Renal disease Due to (or as a consequence of): d. Approximate Interval Between Onset and Death >1 week								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>[Signature]</i>			29c. License number D24504		29d. Date signed (Month, Day, Year) 6-9-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert T Peterson 600 Reelsby Ave Annapolis Md 21401								
31. Date filed (Month, Day, Year) JUN 11 1999			32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18802

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Joseph Jones

2. Date of Death

June

Day

8

Year

1999

3. Time of Death

10:55AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

219-30-1179

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 11, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4611 Homer Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Maintenance

17. Father's Name (First, Middle, Last)

William Byrd Jones

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Jones

19a. Informant's Name/Relationship (Type, Print)

Lorraine Jones/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4611 Homer Avenue Baltimore, Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Date

6/14/99

20c. Location - City or Town, State

Baltimore Co., Maryland

21. Signature of Funeral Service Licensee

Maggie E. Gilmore-Henson

22. Name and Address of Facility

Mortician 5240 Reisterstown Road Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Rectal Carcinoma

Due to (or as a consequence of):

b. Liver Failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Maggie E. Gilmore-Henson

29c. License number

A12331

29d. Date signed (Month, Day, Year)

June 8, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Marvin E. McKenzie, MD 2401 West Belvedere Avenue Baltimore, MD 21215

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18803

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE MAE JONES

2. Date of Death

JUNE 03 1999

3. Time of Death

13:30

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

250-62-1945

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-29-29

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2427 East Federal Street

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

Days work

17. Father's Name (First, Middle, Last)

Thomas J. Myers

18. Mother's Name (First, Middle, Maiden Surname)

Ida Washington

19a. Informant's Name/Relationship (Type, Print)

Melvin B. Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21213
2427 East Federal Street Baltimore, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kings Mem. Pk. Cem. 06-09-99

Date

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
ONE WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SYSTEMIC LUPUS ERYTHEMATOSUS

Due to (or as a consequence of):

TEN YEARS

c. INTERSTITIAL LUNG DISEASE

Due to (or as a consequence of):

FIVE YEARS

d. RENAL FAILURE

TWO WEEKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

SEIZURES

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Baltimore MD MEDICINE RESIDENT

29c. License number

05617

29d. Date signed (Month, Day, Year)

JUNE 03, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARILYN LAWRENCE 600 NORTH WOLFE STREET, TOWER 110, BALTIMORE, MARYLAND, 21287

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

B. Sparks

State
Registrar

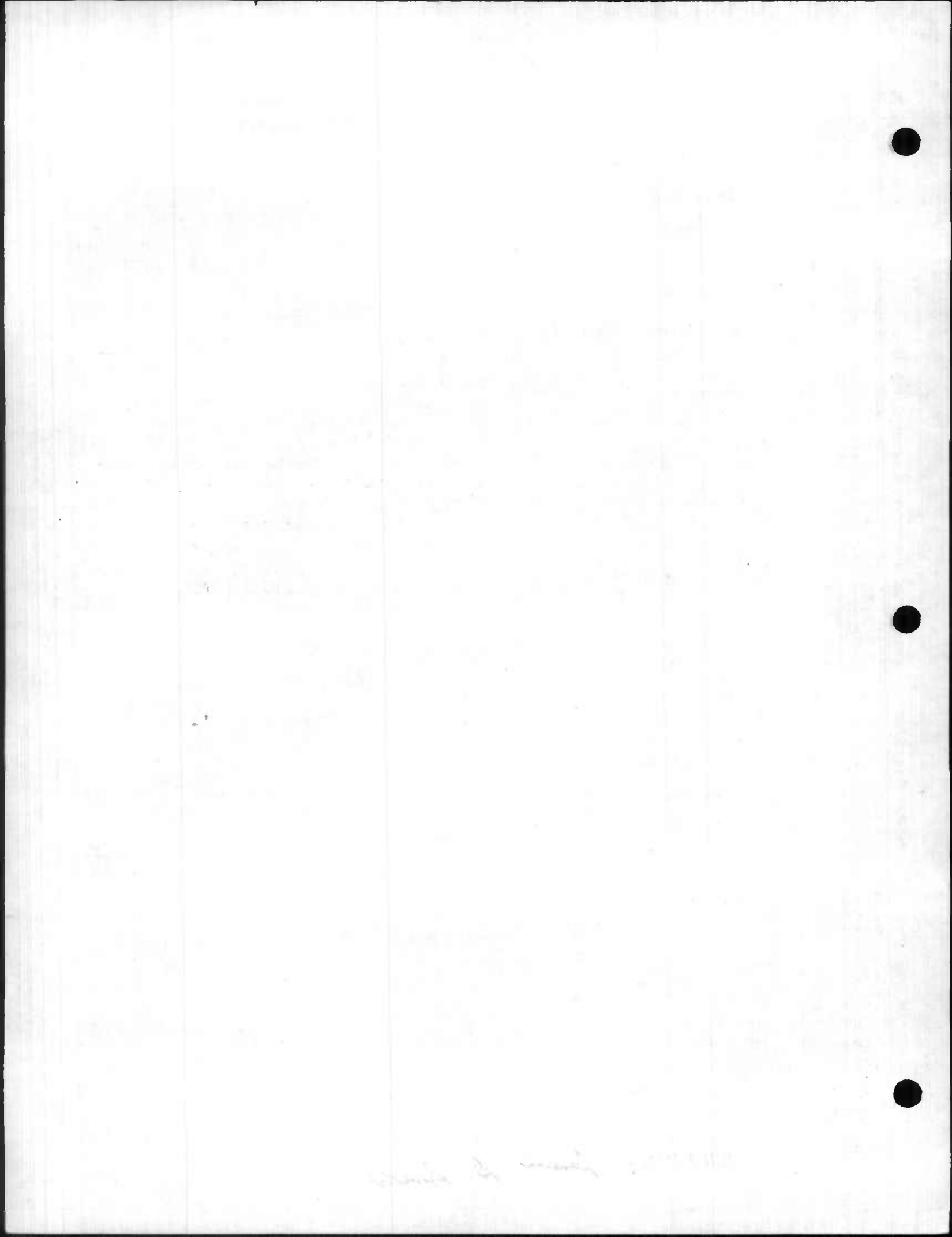
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18804

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROY L. JONES				2. Date of Death Month Day Year JUNE 2, 1999		3. Time of Death 8:00 P.M.								
	4a. Facility Name (If not institution, give street and number) SUNRISE NURSING HOME				4b. City, Town, or Location of Death ELKTON		4c. County of Death CECIL								
Funeral Director	5. Social Security Number 164-07-6555		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT 24, 1911		9. Birthplace (State or Foreign Country) PENNSYLVANIA						
	Usual Residence of Decedent														
10a. State DELAWARE		10b. County SUSSEX		10c. City, Town or Location MILLSBORO				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number R.D. 4 BOX 127				10f. Zip Code 19966		10g. Citizen of What Country? U.S.A.									
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SHIFT SUPERVISOR			16b. Kind of Business/Industry ELECTRIC UTILITY								
17. Father's Name (First, Middle, Last) JAMES ARTHUR JONES				18. Mother's Name (First, Middle, Maiden Surname) MABEL ELIZABETH LOCKE											
19a. Informant's Name/Relationship (Type, Print) ROY L. JONES / SELF				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R.D. 4 BOX 127, MILLSBORO, DELAWARE 19966											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) INDIAN MISSION CEMETERY			Date 6/7/99		20c. Location - City or Town, State MILLSBORO, DELAWARE							
21. Signature of Funeral Service Licensee ▶ <i>Richard T. Watson</i>				22. Name and Address of Facility WATSON FUNERAL HOME, INC. 211 WASHINGTON STREET, MILLSBORO, DELAWARE 19966											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CHF. severe Due to (or as a consequence of): b. Severe Cardiomyopathy Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred						
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier ▶ <i>M. Sander</i>		29c. License number D26183		29d. Date signed (Month, Day, Year) 6/2/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MADHUSACHIDAN 322 E Cecil Ave. North East, MD 21901															
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature ▶ <i>B. Spence</i>											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

197412

DHHM 16 Rev 6/95

ORIGINAL

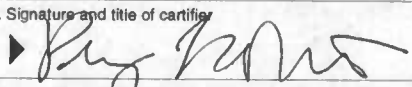
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18805

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Jarzynski		2. Date of Death Month June Day 8 Year 1999		3. Time of Death 6:45 AM
	4a. Facility Name (If not institution, give street and number) Baltimore Rehabilitation & Extended Care		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 214-18-7468	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 12-19-22		9. Birthplace (State or Foreign Country) MD		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD	10b. County Baltimore	10c. City, Town or Location Rosedale		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 1315 Chesaco Ave. Apt. 223		10f. Zip Code 21237		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+) 0		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled		16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) Frank P. Jarzynski		18. Mother's Name (First, Middle, Maiden Surname) Frances Szczesniak		
	19a. Informant's Name/Relationship (Type, Print) Dolores Soltz / sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1315 Chesaco Ave. Apt. 223, Rosedale, MD 21237		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary		20c. Location - City or Town, State 6-11-99 Dundalk, Md
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave., Rosedale, MD 21237		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 2 years
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, Hypertension				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier 		29c. License number D0032548		29d. Date signed (Month, Day, Year) June 8, 1999
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Perry Colvin MD 10 North Greene St Baltimore MD 21201				
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18806

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH M. JONES						2. Date of Death Month Day Year May 21 1999		3. Time of Death 1:50 AM											
	4a. Facility Name (If not institution, give street and number) MANOR CARE-ROSSVILLE						4b. City, Town, or Location of Death BALTIMORE COUNTY		4c. County of Death BALTIMORE											
Funeral Director	5. Social Security Number 212-14-9447		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 9, 1906		9. Birthplace (State or Foreign Country) Maryland											
	Usual Residence of Decedent																			
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore County				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
10e. Street and Number 26 Cliffwood Rd.				10f. Zip Code 21206		10g. Citizen of What Country? USA														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 yrs. N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier			16b. Kind of Business/Industry Glenn L. Martin Co.													
17. Father's Name (First, Middle, Last) Michael Saffer						18. Mother's Name (First, Middle, Maiden Surname) Barbara Doepler														
19a. Informant's Name/Relationship (Type, Print) John M. Jones						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5110 McFaul Rd. Baltimore, Md. 21206														
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. 5-24-1999		20c. Location - City or Town, State Baltimore, Maryland														
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Atrial Fibrillation</td> <td rowspan="4"> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death 6 months. 2 months. </td> </tr> <tr> <td>b.</td> <td>Foot Gangrene</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Atrial Fibrillation	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death 6 months. 2 months.	b.	Foot Gangrene	c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Atrial Fibrillation	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death 6 months. 2 months.																
	b.	Foot Gangrene																		
	c.																			
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred												
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29b. Signature and title of certifier 				29c. License number D45475		29d. Date signed (Month, Day, Year) 5-21-99														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Rahmans 17 Fontana Lane #105 Baltimore MD 21237																				
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature 																

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18807

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) DORIS LUYCLLE KNICK				2. Date of Death Month Day Year JUNE 10, 1999		3. Time of Death 12:50 AM	
4a. Facility Name (If not institution, give street and number) 6815 E. BROOK AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 219-30-9753		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 29, 1933	
9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 6815 E. BROOK AVENUE		10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST		16b. Kind of Business/Industry BOOK BINDERY			
17. Father's Name (First, Middle, Last) RAYMOND MIGGS BUCK				18. Mother's Name (First, Middle, Maiden Surname) DORIS SCHWINK			
19a. Informant's Name/Relationship (Type, Print) OMAR LEE KNICK (HUSBAND)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6815 E. BROOK AVENUE, BALTIMORE, MD. 21224			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EPIPHANY EPISCOPAL CHURCH CEMETERY		Date 6/12/99		20c. Location - City or Town, State ODENTON, MD.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier Larry Waterbury, M.D.
29c. License number 20 9559							29d. Date signed (Month, Day, Year) 6/10/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LARRY WATERBURY, MD JHBAC 4940 EASTERN AVE., Balt., Md. 21224							
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18808

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Irene F. Kopec				2. Date of Death Month Day Year June 9 1999		3. Time of Death 6:15 P.M.			
	4a. Facility Name (If not institution, give street and number) 505 Jeffrey Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director	5. Social Security Number 216 60 9385		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 25, 1915		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 505 Jeffrey Street				10f. Zip Code 21225		10g. Citizen of What Country? U.S.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) John David				18. Mother's Name (First, Middle, Maiden Surname) Lucille Gawlik					
	19a. Informant's Name/Relationship (Type, Print) Adele Kopec / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Jeffrey Street Baltimore, Maryland 21225					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		Data 6/14/99		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signatures of Funeral Service Licensee <i>Donna J. Zimionich</i>				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER OF PANCREAS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 YEAR Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Mark C. [Signature]</i> MD		29c. License number D0052387		29d. Date signed (Month, Day, Year) 6/10/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUKUL KHANDLWAL MD 3007 S. HANOVER BALTIMORE, MD 21225										
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18809

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CONCETTA KARN				2. Date of Death Month Day Year JUNE 10 1999		3. Time of Death 4:30 AM	
	4a. Facility Name (If not institution, give street and number) 109 BLOOMSBERRY STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-36-8215		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) March 24 1939	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 109 Bloomsberry Street		10f. Zip Code 21230		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk		16b. Kind of Business/Industry Eastern Standards				
17. Father's Name (First, Middle, Last) Frank DiBlasi				18. Mother's Name (First, Middle, Maiden Surname) Concetta Brace				
19a. Informant's Name/Relationship (Type, Print) Margaret Pippin (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Bloomsberry Street, Baltimore, Md. 21230				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 6/14/99 Brooklyn Park, Md.				
21. Signature of Funeral Service Licensee Christina P. Halton		22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave., Baltimore, Md. 21230						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Endometrial carcinoma 7 months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Gayatri Nimmagadda		29c. License number D 39041		29d. Date signed (Month, Day, Year) June 10th 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAYATRI NIMMAGADDA 3001 S. Hanover Street Baltimore MD 21225								
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18810

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeffrey C. Loker				2. Date of Death Month Day Year JUNE 10, 1999		3. Time of Death 8:33 AM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 510-40-7055		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 17, 1942	9. Birthplace (State or Foreign Country) Missouri
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Crownsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 1208 Fairfield Lane				10f. Zip Code 21032		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1959/1963		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Consultant			16b. Kind of Business/Industry Computer		
	17. Father's Name (First, Middle, Last) Raymond Loker				18. Mother's Name (First, Middle, Maiden Surname) Christine Calhoun			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kathryn Simpson/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Fairfield Ln, Crownsville, MD 21032			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 06/11/99		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. glio blastoma multiforme Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							Approximate Interval Between Onset and Death 2 1/2 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier W. A. Riley, MD				29c. License number D25205		29d. Date signed (Month, Day, Year) June 10, 1999		
30. Name and address of person who completed cause of death (from 23a) (Type, Print) W. A. Riley, 6601 N. Charles St. Balto. MD 21204								
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature B. Sparks						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18811

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Gertrude Leidy				2. Date of Death Month Day Year June 10 1999				3. Time of Death 4:55 AM	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE				4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 196-24-2651		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 5-2-1921		9. Birthplace (State or Foreign Country) PA		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Millersville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4 Bojan Court		10f. Zip Code 21108		10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 44-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse	
	16b. Kind of Business/Industry Nursing		17. Father's Name (First, Middle, Last) Frank Freeh		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Kresbh		19a. Informant's Name/Relationship (Type, Print) Paul K. Leidy / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Bojan Court Millersville MD 21108	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center, LLC.		Date 6/10/99		20c. Location - City or Town, State Stevensville, MD		21. Signature of Funeral Service Licensee	
	22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Ave. S.W., Glen Burnie, MD. 21061		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or trauma. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Thrombosis		Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):		Due to (or as a consequence of):					
	Due to (or as a consequence of):									
	Due to (or as a consequence of):									
	Due to (or as a consequence of):									
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature] MD		29c. License number D-95149		29d. Date signed (Month, Day, Year) June 10 1999				
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONABAYO. 301 HOSPITAL DRIVE GLEN BURNIE MD 21061				31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature [Signature]	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature or initials.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item #1, per phy, 6/11/99, G772, gap

Certificate of Death

Reg. No.

99 18812

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) <u>TAKOMA THOMAS LAMBERT</u>				2. Date of Death Month <u>06</u> Day <u>05</u> Year <u>99</u>		3. Time of Death <u>01:28</u>	
4a. Facility Name (If not institution, give street and number) <u>UMMS</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>BALTIMORE CITY</u>	
5. Social Security Number <u>N/A</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>N/A</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>JUNE 4, 1999</u>	9. Birthplace (State or Foreign Country) <u>MARYLAND</u>
Usual Residence of Decedent							
10a. State <u>MARYLAND</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>BALTIMORE</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>1131 W. CROSS STREET, 2ND FLOOR</u>				10f. Zip Code <u>21230</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>INDIAN</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>N/A</u> Collega (1-4or 5+) <u>N/A</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>N/A</u>		16b. Kind of Business/Industry <u>N/A</u>	
17. Father's Name (First, Middle, Last) <u>(UNKNOWN)</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>LOIS LAMBERT</u>			
19a. Informant's Name/Relationship (Type, Print) <u>LOIS LAMBERT (MOTHER)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>21230</u> <u>1131 W. CROSS STREET, 2ND FLOOR, BALTIMORE, MD.</u>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>GLEN HAVEN MEMORIAL PARK</u>		Data <u>6/9/99</u>		20c. Location - City or Town, State <u>GLEN BURNIE, MD.</u>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>SINGLETON FUNERAL HOME, P.A.,</u> <u>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. RESPIRATORY FAILURE</u> Due to (or as a consequence of): <u>b. OSTEOPENESIS IMPERFECTA, TYPE II</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred <u>N/A</u>				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <u>McKanyigye - MD.</u>				29c. License number <u>DO054155</u>		29d. Date signed (Month, Day, Year) <u>6/5/99</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>CATHERINE KANYESIGYE MUHUMUZA, M.D.</u> <u>UMMS, 22 SOUTH GREEN ST. BALTIMORE, MD 21201</u>							
31. Date filed (Month, Day, Year) <u>JUN 11 1999</u>				32. Registrar's Signature <u>[Signature]</u>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

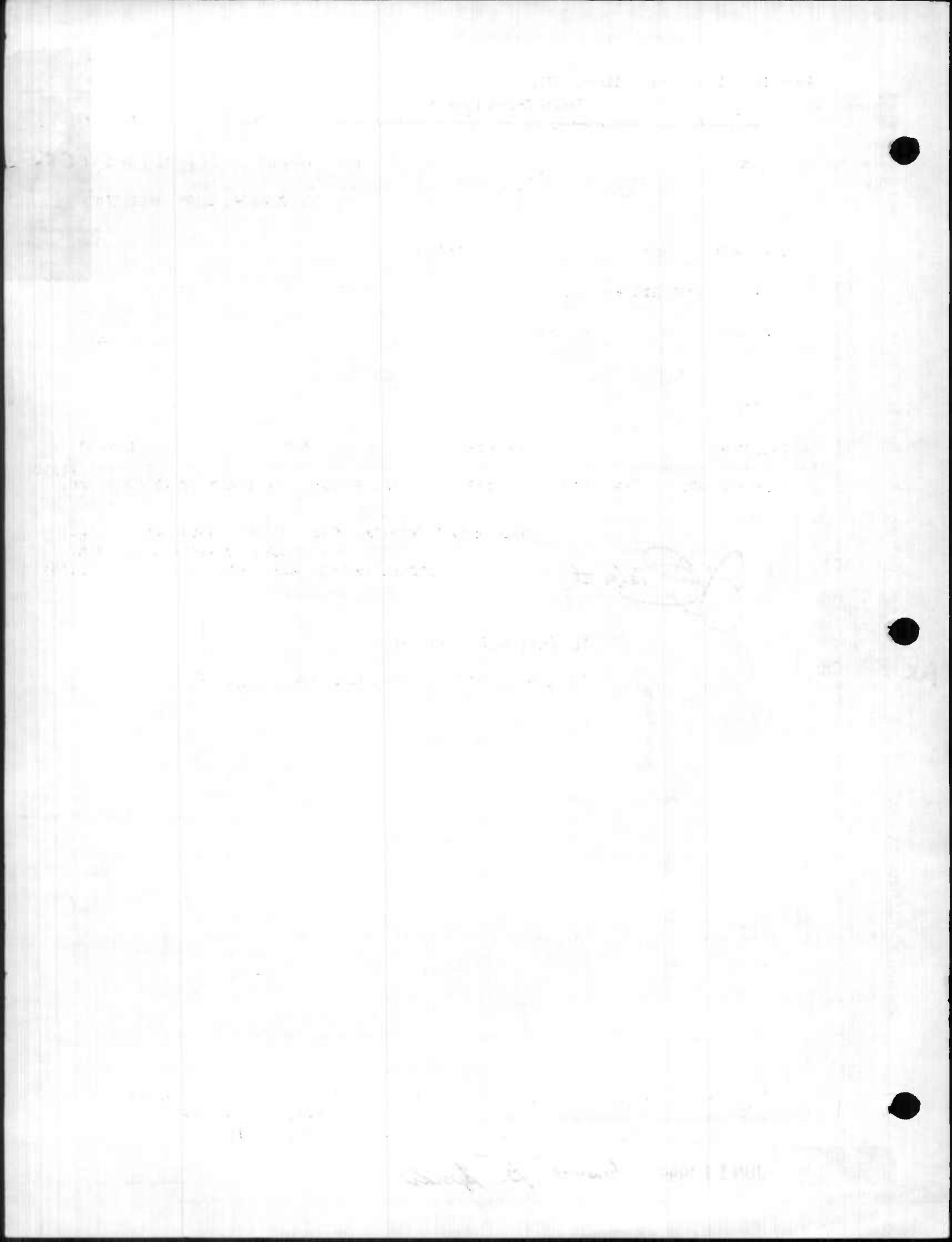
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18813

LOWE, JAMES D.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

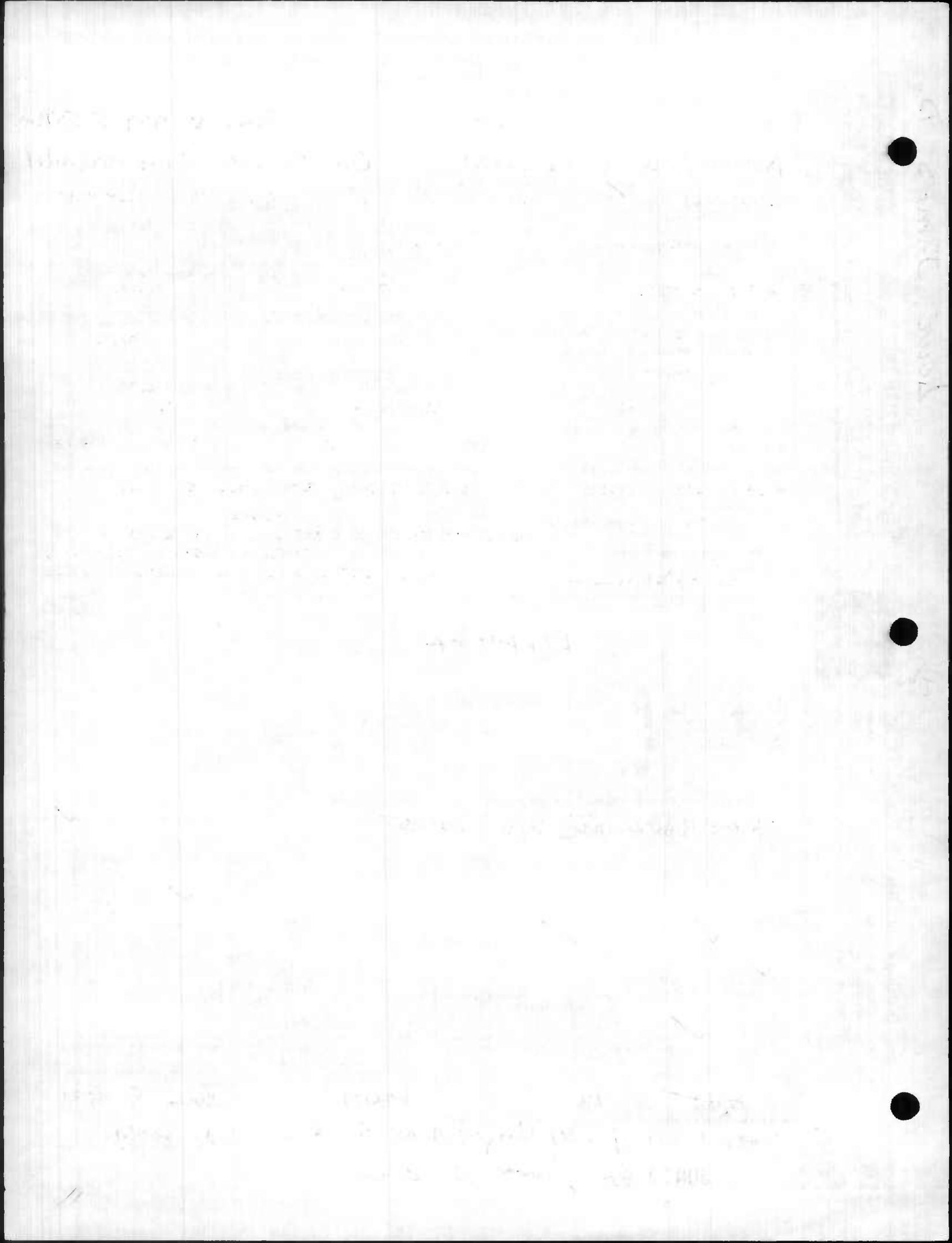
Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) JAMES D. LOWE		2. Date of Death Month June Day 8 Year 1999		3. Time of Death 5:55 A.M.	
4a. Facility Name (If not institution, give street and number) NORTH Arundel Hospital		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
5. Social Security Number 234-10-7843	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 5, 1912
9. Birthplace (State or Foreign Country) WEST VIRGINIA					
Usual Residence of Decedent					
10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1416 ISTED ROAD		10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) +2 College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICIAN		16b. Kind of Business/Industry INDEPENDENT CONTRACTOR	
17. Father's Name (First, Middle, Last) ROBERT E. LOWE		18. Mother's Name (First, Middle, Maiden Surname) LOLA PENNINGTON HOSLER			
19a. Informant's Name/Relationship (Type, Print) RUTH C. LOWE (WIFE)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1416 ISTED ROAD, GLEN BURNIE, MD. 21060			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CENTER, LLC.		20c. Location - City or Town, State STEVENSVILLE, MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LYMPHOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier  MD		29c. License number D43977		29d. Date signed (Month, Day, Year) June 8 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amber Okefunji, 301 Hospital Drive, Glen Burnie, MD. 21061					
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18814

AMEND ITEM#24a PER PHYNS G772 6-11-99 J.A. *Certificate of Death*

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edith A Ladd

2. Date of Death

May 17, 1999

3. Time of Death

4:10 p.m.

4a. Facility Name (If not institution, give street and number)

1537 Shipview Road

4b. City, Town, or Location of Death

Annapolis, MD

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

018-32-3415

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 24, 1942

9. Birthplace (State or Foreign Country)

Mass.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1537 Shipview Road

10f. Zip Code

21401

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
216a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Planner

16b. Kind of Business/Industry

Financial

17. Father's Name (First, Middle, Last)

Edwin H. Russell

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Isabelle Leighton

19a. Informant's Name/Relationship (Type, Print)

Richard Ladd/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1537 Shipview Road, Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Metastatic Cancer to Brain

3 months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Lung Cancer

3 months

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Jeanine Werner, MD

29c. License number

D0052830

29d. Date signed (Month, Day, Year)

May 19, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jeanine Werner, MD 900 Bestgate Road, Suite 300 Annapolis, MD 21401

State
Registrar

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

Bernard B. Sparks

Baltimore, Maryland 21215-0020

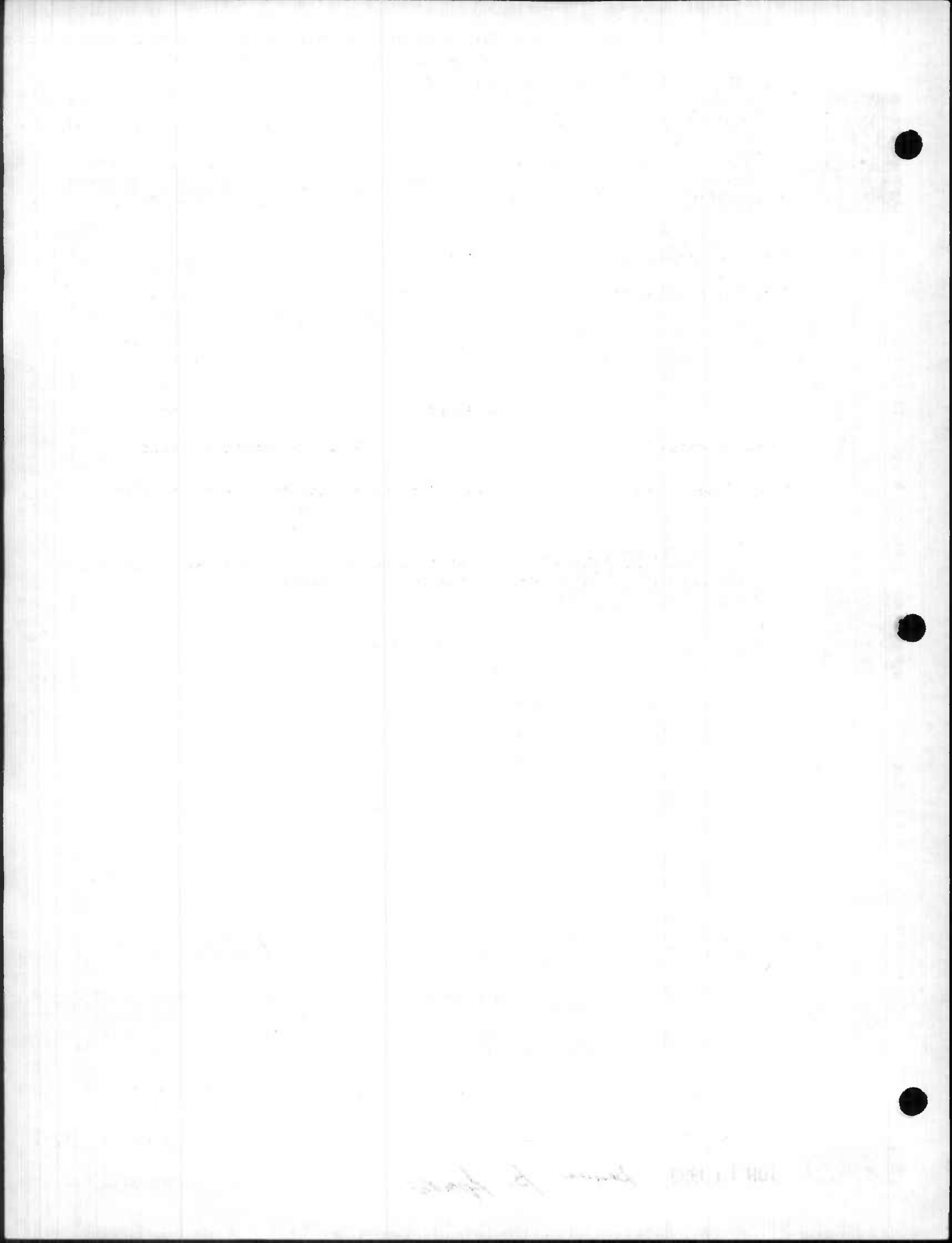
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18815

RICHARD MACKLIN JUNE 9, 1999 8:20 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Edward Macklin				2. Date of Death Month Day Year 6 9 1999		3. Time of Death 8:20 a.m.	
	4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-46-0535	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4 10 1947		9. Birthplace (State or Foreign Country) Md
	Usual Residence of Decedent							
10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 5702 Radecke Avenue				10f. Zip Code 21206		10g. Citizen of What Country? U S A		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) N/A				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cargo Worker			16b. Kind of Business/Industry B. W. I.	
17. Father's Name (First, Middle, Last) Henry T. Macklin				18. Mother's Name (First, Middle, Maiden Surname) Laura L. Brown				
19a. Informant's Name/Relationship (Type, Print) Willie Macklin- Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5702 Radecke Avenue Baltimore, Md 21206				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Date 6-14-99		20c. Location - City or Town, State Randallstown, Md		
21. Signature of Funeral Service Licensee Gabrielle Clark				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. PANCREATIC CANCER Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Tariq				29c. License number D43725		29d. Date signed (Month, Day, Year) 6/11/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093								
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature B. Sparks				

State Registrar
DHMH 16 Rev 6/95

ORIGINAL

and a...

CODE 1.1.1.1.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18816

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ava M. Marshall				2. Date of Death Month Day Year JUNE 5, 1999		3. Time of Death 5:07 PM		
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death AA COUNTY		
Funeral Director	5. Social Security Number 049-36-2750		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 31 1911		
	9. Birthplace (State or Foreign Country) PA		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Riva		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3073 Riverview Rd.		10f. Zip Code 21140		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical		16b. Kind of Business/Industry Law		17. Father's Name (First, Middle, Last) John Backenstose		18. Mother's Name (First, Middle, Maiden Surname) Stella Brendle		19a. Informant's Name/Relationship (Type, Print) Elizabeth Marshall/daughter	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Parchment Ct., Cary, NC 27511		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Schaefferstown Cemetery		20c. Location - City or Town, State 6/10/99 Schaefferstown, PA		21. Signature of Funeral Service Director Michael J. Flagle	
22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR FIBRILLATION Due to (or as a consequence of): b. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): c. ATHEROSCLEROTIC CORONARY ARTERY DISEASE Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death MINUTES MINUTES YRS		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA, ACUTE BRONCHITIS, DEPRESSION Cerebrovascular Disease		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier R. Ramaratnam MD		29c. License number 00054288		29d. Date signed (Month, Day, Year) June 5, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Ramaratnam 7445 E FURNACE Borch Rd GLEN BURNIE MD 21060		31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature B. Sparks					

MARSHALL AVA B.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

AAH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18817

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLADYS MARKLINE				2. Date of Death Month Day Year JUNE 11, 1999				3. Time of Death 3:06 pm	
	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL				4b. City, Town, or Location of Death BALTO. CITY				4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-07-6335		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) Sept 19, 1901		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore City				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 2211 W. Rogers Avenue				10f. Zip Code 21211		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Chemical Manufacturing		
	17. Father's Name (First, Middle, Last) Phillip Markline				18. Mother's Name (First, Middle, Maiden Surname) Margaret King					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (Nephew) Charles F. Hoffmaster in-Law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3410 Chapman Road, Randallstown, MD 21133					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Vernon Meth Ch Cem.		Date 6/11/99		20c. Location - City or Town, State White Hall, Maryland			
	21. Signature of Funeral Service Licensee Martin D. Dawson				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Henri Hammour M.D.		29c. License number D35890		29d. Date signed (Month, Day, Year) 6/7/99			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HENRI HAMMOUR MARYLAND GENERAL HOSPITAL									
	31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature B. Sparks							

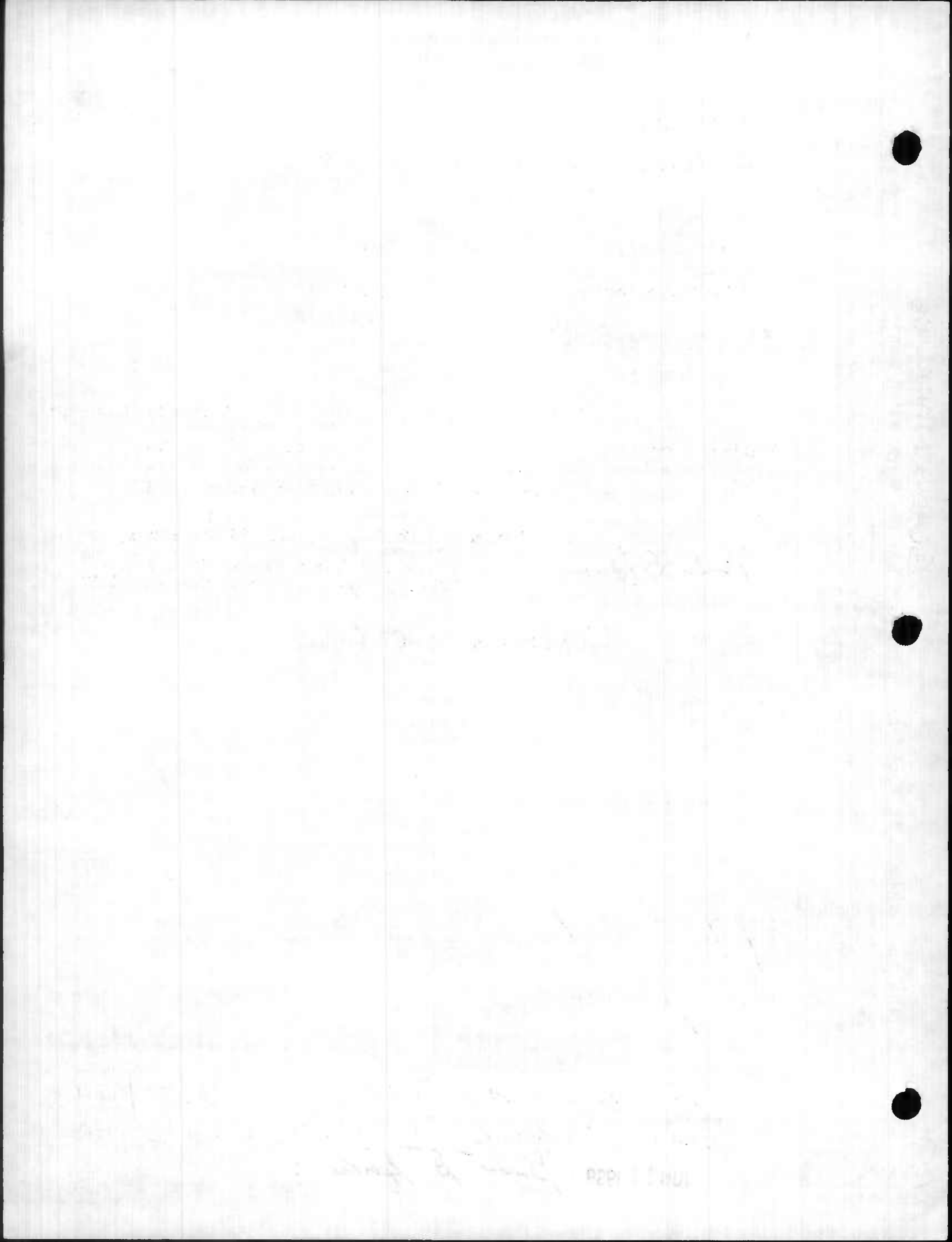
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



99-3251-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

WILLIAM

State of Maryland / Department of Health and Mental Hygiene

99 18818

MOORE AMEND ITEMS: #23 PART I, PER MEO G775 9-9-99 WR. *Certificate of Death*

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William R. Moore				2. Date of Death Month: JUNE Day: 8 Year: 1999		3. Time of Death 4:44 P.M.	
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 219-66-5022		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) 1 16 59	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) Maryland		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State Md.		10b. County NIA		10c. City, Town or Location Baltimore		10d. Inside City Limits		
10e. Street and Number 1821 N. Washington St.				10f. Zip Code 21213		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 10th Collega (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Man		16b. Kind of Business/Industry Larry Pollak Office Inc.		
17. Father's Name (First, Middle, Last) William M. Moore				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Williams				
19a. Informant's Name/Relationship (Type, Print) Evelyn Moore - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1821 Washington St. Balto. Md. 21213				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Cemetery		20c. Date 6-15-99		20d. Location - City or Town, State Balto. Md.		
21. Signature of Funeral Service Licensee Jeff Miller				22. Name and Address of Facility Jeff Miller P.C. Funeral Home & Services 1639 Broadway Balto. Md. 21213				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hemorrhage. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. CARDIAC ARRHYTHMIA DURING AGITATION AND RESTRAINT Due to (or as a consequence of): b. MENINGOENCEPHALITIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 6-8-99		28b. Time of Injury 3:25 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred UNKNOWN		28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) BALTIMORE CITY CORRECTIONS CENTER		28f. Location (Street and Number or Rural Route Number, City or Town, State) 901 GREENMOUNT AVENUE, BALTIMORE MD.		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Wayne Brubaker MD				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 9, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne Brubaker MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

A4 1

RECEIVED AT NEW YORK CITY

APRIL 1951

Handwritten signature and date: 10/1/51

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18819

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Mae Matrangola				2. Date of Death Month Day Year JUNE 3, 1999		3. Time of Death 7:30pm		
	4a. Facility Name (If not institution, give street and number) 2 BALDWIN COURT - APT-A				4b. City, Town, or Location of Death CATONSVILLE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 214-20-9143		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) February 28, 1926		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2 Baldwin Court - Apt-A				
	10f. Zip Code 21228				10g. Citizen of What Country? United States				
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2yr		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Examiner		16b. Kind of Business/Industry Social Security Admin.				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) George M. Smith				18. Mother's Name (First, Middle, Maiden Surname) Martha C. Parker				
	19a. Informant's Name/Relationship (Type, Print) George H. Smith/Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2526 Marbourne Avenue Baltimore, Maryland 21230				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 6/7/99		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee <i>Jackie D. Shannon</i>				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Cerebrovascular accident</i> Due to (or as a consequence of): <i>Hypertensive atherosclerotic</i> Due to (or as a consequence of): <i>cardio vascular disease</i> Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <i>years</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>Alejandro Mejia</i>				29c. License number 208780		29d. Date signed (Month, Day, Year) June 4, 1999.		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ALEJANDRO MEJIA - 405 FREDERICK ROAD - SUITE 100 - CATONSVILLE, MD 21228								
	31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature <i>B. Sparks</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18820

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) RENA M. MILLS				2. Date of Death Month Day Year JUNE 10 1999		3. Time of Death 9 45 AM	
4a. Facility Name (If not institution, give street and number) GENESIS HAMMONDS LANE NURSING				4b. City, Town, or Location of Death BROOKLYN PARK		4c. County of Death ANNE ARUNDEL	
5. Social Security Number 410-54-6310		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) AUG 12, 1915	
9. Birthplace (State or Foreign Country) TENNESSEE		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 915 LEEDS AVENUE		10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER		16b. Kind of Business/Industry GROCERY STORE			
17. Father's Name (First, Middle, Last) CHARLIE CURTIS McDANIEL				18. Mother's Name (First, Middle, Maiden Surname) NANCY JANE GREENE			
19a. Informant's Name/Relationship (Type, Print) ALPHIA J. FLOWERS (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 LEEDS AVENUE - BALTIMORE, MARYLAND 21229			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CRESTLAWN MEMORIAL GARDEN		20c. Date 6/12/99		20d. Location - City or Town, State MARRIOTTSTVILLE, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229			

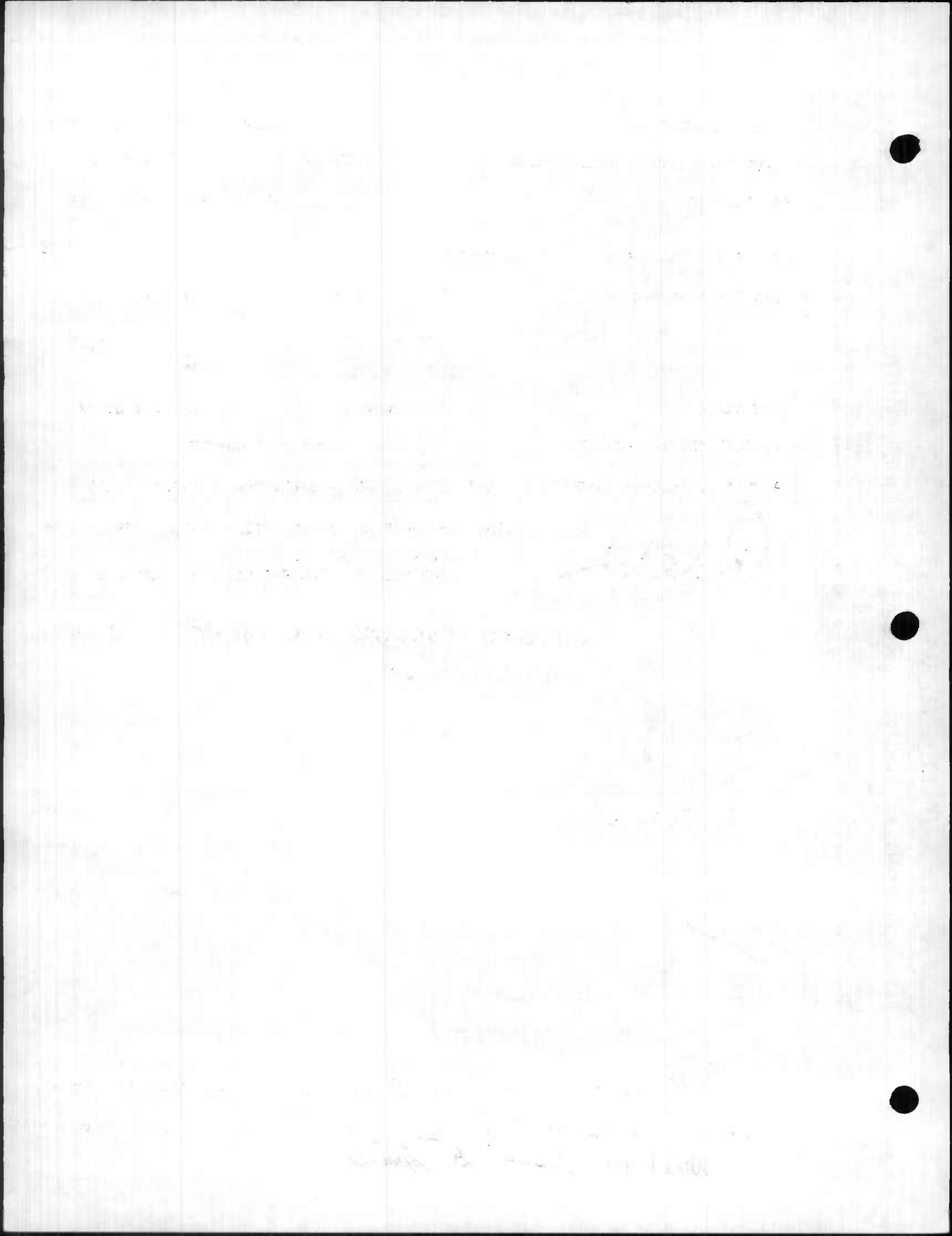
Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DIABETES				Approximate Interval Between Onset and Death 2 WEEKS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier 		29c. License number D 21776		29d. Date signed (Month, Day, Year) JUNE 11 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUPRA MENDRA MD 3001 S HANOVER ST BALTIMORE 21229					
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18821

AMENDED ITEM #18 PER FH G773 7/23/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James F. Mahorney

2. Date of Death

Month June Day 9 Year 1999

3. Time of Death

0724

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

214-56-3756

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Dec. 13, 1950 MD

Usual Residence of Decedent

10e. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

37 Ojibway Road

10f. Zip Code

21133

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: Vietnam13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Ass. Chief Property Manager

16b. Kind of Business/Industry

Maryland State
Dept. of Transportation

17. Father's Name (First, Middle, Last)

Bernard Mahorney

18. Mother's Name (First, Middle, Maiden Surname)

Donna Sage GLADYS MARIE SAGE

19a. Informant's Name/Relationship (Type, Print)

Bernard Mahorney (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

827 Joppa Farm Road, Joppatowne, MD 21085

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Balto. Washington Crematory

Date

6/14/99

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Robert Gregory Buchan

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. metabolic acidosis

Approximate
Interval Between
Onset and Death

2-4 hours

Due to (or as a consequence of):

b. hyperkalemia

2-4 hours

Due to (or as a consequence of):

c. bleeding

4-6 hours

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

end stage renal disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Jorge D. Salazar MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

June 9, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jorge D. Salazar

600 North Wolfe Street
Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1941-42 DATE 1941-42

1941-42 DATE 1941-42

1941-42 DATE 1941-42

1941-42 DATE 1941-42

1941-42 DATE 1941-42

1941-42 DATE 1941-42

1941-42 DATE 1941-42

1941-42 DATE 1941-42

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1941-42 DATE 1941-42

1941-42 DATE 1941-42

1941-42 DATE 1941-42

1941-42 DATE 1941-42

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18822

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Franklin Mason				2. Date of Death Month: June Day: 2 Year: 1999		3. Time of Death 6:00 p	
	4a. Facility Name (If not institution, give street and number) 2419 Reisterstown Rd.				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 238-30-8387		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 23, 1923	
	9. Birthplace (State or Foreign Country) NC		10e. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 2419 Reisterstown Rd.				10f. Zip Code 21217		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 5/12/43 If Yes, Give Year or Dates: 10/23/43		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Self-Employed	
	17. Father's Name (First, Middle, Last) Bartohlomew Mason				18. Mother's Name (First, Middle, Maiden Surname) Victoria Mason			
	19a. Informant's Name/Relationship (Type, Print) Leanna Mason/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 N. Ellamont St., Baltimore, MD 21229			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem.		20c. Location - City or Town, State Owings Mills, MD		20d. Date 6/11/99	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Irvin P. Carroll Funeral Home 1712-14 W. North Ave., Baltimore, MD 21217			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. lung cancer Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Physician /Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number D32186		29d. Date signed (Month, Day, Year) 6-10-99	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CONRAD MAY, MD BALTIMORE VAMC 10 N. GREENE ST. BALTIMORE, MD 21201							
State Registrar	31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature 			

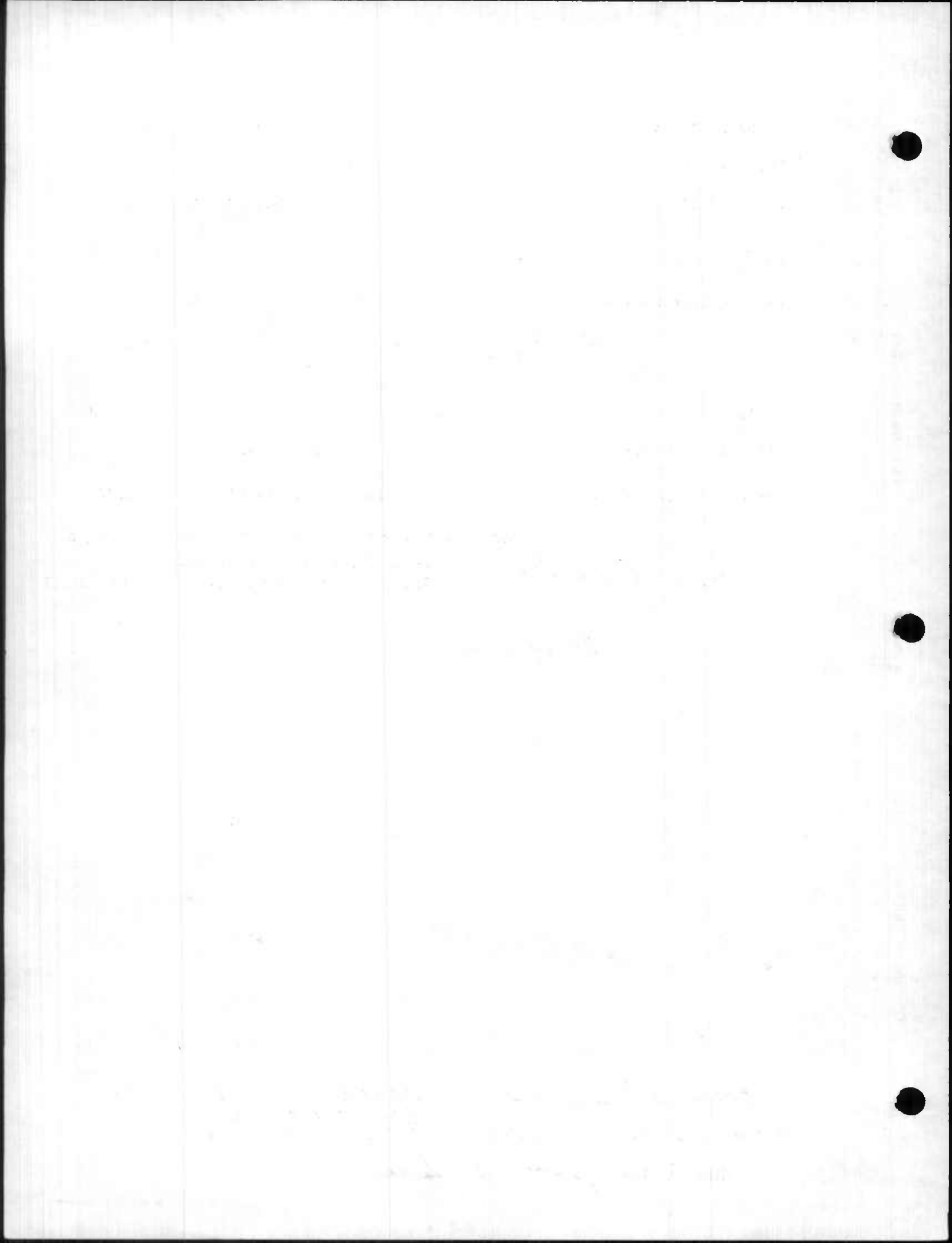
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18823

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jerome L. Moore				2. Date of Death Month June Day 7 Year 1999		3. Time of Death 7:13 AM	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 212-46-5135		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) 12-24-47	
	10e. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Usual Residence of Decedent				10f. Zip Code 21215		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry various trades		
17. Father's Name (First, Middle, Last) Elbert Moore				18. Mother's Name (First, Middle, Maiden Surname) Inez Hughes				
19a. Informant's Name/Relationship (Type, Print) Inez Moore				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 3625 W. Belvedere Avenue Baltimore, MD.				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hughes Family Plot		20c. Location - City or Town, State 06-12-99 Shiloh, NC		
21. Signature of Funeral Service Licensee Bernard D. Johnson				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March F H 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Small Cell Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Tobacco Use								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Darin Epstein M.D.				29c. License number AS2402321-DE-9152		29d. Date signed (Month, Day, Year) June 7, 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Darin Epstein, Sinai Hospital, Baltimore, MD								
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature Gene B. Sparks				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

ELSIE
NEWSOME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18824

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elsie B. Newsome				2. Date of Death Month Day Year JUNE 9, 1999		3. Time of Death 9:34 P.M.	
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-10-9890		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Dec 1, 1911	
	9. Birthplace (State or Foreign Country) VA		10a. State MD		10b. County Baltimore		10c. City, Town or Location Edgemere	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2621 Edgemere Ave		10f. Zip Code 21219		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) Thomas Turner				18. Mother's Name (First, Middle, Maiden Surname) Nora Meredith				
19a. Informant's Name/Relationship (Type, Print) Susan Pharoan /daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Walker Ave Baltimore, MD 21212				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		Date June 14 1999		20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee <i>Anthony C. Connelly</i>				22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Stephen S. Radentz</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 10, 1999		
30. Name and address of person who completed cause of death (Item 25a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature <i>Benjamin B. Sparks</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ATK3

Book 4 - January 1900

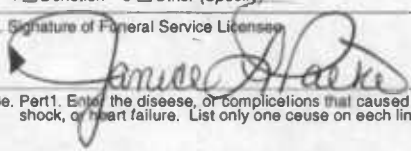
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18825

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MICHAEL J. O'ROURKE, SR				2. Date of Death Month Day Year June 11 1999		3. Time of Death 5:15 AM	
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 215-12-2592		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 17, 1920	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George		10c. City, Town or Location Laurel			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 603 Carroll Avenue				10f. Zip Code 20707		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Servant			16b. Kind of Business/Industry Federal Government	
17. Father's Name (First, Middle, Last) Patrick Francis O'Rourke				18. Mother's Name (First, Middle, Maiden Surname) Rosalie McDermott				
19a. Informant's Name/Relationship (Type, Print) Margaret O'Rourke/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Carroll Avenue, Laurel, Maryland 20707				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Church Cem.		Date 6/14/99		20c. Location - City or Town, State Laurel, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS FROM URINARY TRACT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DAYS Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEVERE PARKINSONS DISEASE CORONARY ARTERY DISEASE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D24997		29d. Date signed (Month, Day, Year) 6/11/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LUIS A. CASAS MD 8319 CHERRY LANE LAUREL MD 20707								
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

1941

1941

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18826

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JANMEJAYA PATEL

2. Date of Death

June 7 1999

3. Time of Death

11:18P

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

217-98-0313

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 15, 1934

9. Birthplace (State or Foreign Country)

Uganda

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Highland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13418 Good Times Court

10f. Zip Code

20777

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify Asian Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Businessman

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Manganbhai Patel

18. Mother's Name (First, Middle, Maiden Surname)

Maniben Patel

19a. Informant's Name/Relationship (Type, Print)

Jaya J. Patel/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13418 Good Times Ct. Highland, MD 20777

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 06/10/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Ischemia

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Diabetes mellitus

Approximate Interval Between Onset and Death

minutes

years

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patricia A. Toye MD

29c. License number

D31473

29d. Date signed (Month, Day, Year)

June 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JANUARY 1941

June 1 1941 11:15

Diabetes mellitus
 Hypertension
 Atherosclerotic Cardiovascular Disease
 Acute Myocardial Infarction

months
 years
 years
 years

X

X

X

X
X

X

Patricia A. Love and
 D. B. Love

Patricia A. Love and D. B. Love (one half each) and W.D. Love

June 1 1941

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18827

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dhruvi R Patel

2. Date of Death

June 04 1999

3. Time of Death

1845 p

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

214-35-9742

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

27 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 3, 1971

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Indian Head

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

4640 Strauss Avenue

10f. Zip Code

20640

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Asian
Indian15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Motel

17. Father's Name (First, Middle, Last)

Vinubhai Chandubhai Patel

18. Mother's Name (First, Middle, Maiden Surname)

Champaben Vinubhai Patel

19a. Informant's Name/Relationship (Type, Print)

Chirayu Patel/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4640 Strauss Avenue, Indian Head, Maryland 20640

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Baltimore Washington Cr.

Data

6/6

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Septic Shock

18 days

Due to (or as a consequence of):

b. Disseminated Intravascular Coagulation

18 days

Due to (or as a consequence of):

c. Hemorrhagic Shock

18 days

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)
May 16, 199928b. Time of
Injury

1200 PM

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

complication of labor

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

hospital

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. H. Friedman

29c. License number

D47427

29d. Date signed (Month, Day, Year)

June 04, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gayle Friedman 9711 Medical Center Drive, Rockville MD 20850

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

L. S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
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To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

99 18828

1. Decedent's Name (First, Middle, Last)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

State
gistrar

ORIGINAL

2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18829

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NANNIE ELIZABETH PARRISH				2. Date of Death Month Day Year JUNE 8, 1999		3. Time of Death 3:45 PM		
	4a. Facility Name (If not institution, give street and number) 705 OLD WAUGH CHAPEL ROAD				4b. City, Town, or Location of Death ODENTON		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 218-22-6623		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 10, 1915		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ODENTON		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 705 OLD WAUGH CHAPEL ROAD		10f. Zip Code 21113		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CASHIER		16b. Kind of Business/Industry ARMED FORCES EXCHANGE					
17. Father's Name (First, Middle, Last) WILLIAM EDWARD VOSS				18. Mother's Name (First, Middle, Maiden Surname) ELISHA HART					
19a. Informant's Name/Relationship (Type, Print) THELMA KATHLEEN KING (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 OLD WAUGH CHAPEL ROAD, ODENTON, MD. 21113					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK		Date 6/11/99		20c. Location - City or Town, State ELKRIDGE, MD.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): b. Chronic obstructive lung disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D 20654		29d. Date signed (Month, Day, Year) 6/8/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YEONG OH 1412 Loran Hw N Gb MD 21061									
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18830

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANN POLLY				2. Date of Death Month Day Year JUNE 08 1999		3. Time of Death 5:55pm										
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death										
Funeral Director	5. Social Security Number 217-20-3279		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) JULY 04 1919										
	9. Birthplace (State or Foreign Country) West Virginia		10a. State MD		10b. County Baltimore		10c. City, Town or Location Essex										
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2227 Monocacy Road		10f. Zip Code 21221		10g. Citizen of What Country? USA											
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Domestic													
17. Father's Name (First, Middle, Last) (Unknown) Skarzinski				18. Mother's Name (First, Middle, Maiden Surname) Mary (Unknown)													
19a. Informant's Name/Relationship (Type, Print) Jennifer Skarzinski/Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6939 Eastbrook Ave. Baltimore Maryland 21224													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cemetery June 11		20c. Location - City or Town, State Baltimore Maryland													
21. Signature of Funeral Service Licensee Kathleen Weber LFSP				22. Name and Address of Facility David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore Maryland 21231													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. NEUTROPENIC FEVERS Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 1 WEEK</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. CHEMOTHERAPY Due to (or as a consequence of):</td> <td>2 WEEK</td> </tr> <tr> <td>c. B CELL LYMPHOMA Due to (or as a consequence of):</td> <td>UNKNOWN</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. NEUTROPENIC FEVERS Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 WEEK	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CHEMOTHERAPY Due to (or as a consequence of):	2 WEEK	c. B CELL LYMPHOMA Due to (or as a consequence of):	UNKNOWN	d.	
Immediate Cause (Final disease or condition resulting in death)	a. NEUTROPENIC FEVERS Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 WEEK															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CHEMOTHERAPY Due to (or as a consequence of):	2 WEEK															
	c. B CELL LYMPHOMA Due to (or as a consequence of):	UNKNOWN															
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number 98031 JH ID NC		29d. Date signed (Month, Day, Year) JUNE 8, 1999											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SEMEGA-JANNECH JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE, MD 21224																	
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature [Signature]															

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Allen L. Ringgold III				2. Date of Death Month Day Year JUNE 6, 1999		3. Time of Death 0034 AM	
	4a. Facility Name (If not institution, give street and number) 6000 BLOCK HARFORD ROAD- REAR PARKING LOT				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-17-1094		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 23 Yrs.		8. Date of Birth (Month, Day, Year) 01 30 1976	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD.		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 5515 Groveland Avenue		10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mail Sorter		16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) Allen L. Ringgold Jr.				18. Mother's Name (First, Middle, Maiden Surname) Betty Singletary			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Allen L. Ringgold/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5515 Groveland Ave. Baltimore, Mw. 21215			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State 6/11/99 Woodlawn, Md.		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Director <i>[Signature]</i>				22. Name and Address of Facility William C. Brown Community Funeral Home 1206 W. North Ave. Baltimore, Md. 21217			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Gunshot Wounds Due to (or as a consequence of): a. _____ Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE				27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) 6/6/99				28b. Time of Injury 0031 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred Subject shot				28e. Location (Street and Number or Rural Route Number, City or Town, State) Street; Rear of 6000 Block Harford Rd; Baltimore, Md			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>[Signature]</i> M.D.				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JUNE 6, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature <i>[Signature]</i>			
	State Registrar							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#5 perFHG772 6/15/99 EW

Certificate of Death

Reg. No.

99 18832

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT BARLETT REGAN				2. Date of Death Month Day Year June 8, 1999		3. Time of Death 7:23am														
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death AACOUNTY														
Funeral Director	5. Social Security Number 303-16-2061		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 18 1928														
	9. Birthplace (State or Foreign Country) New Hampshire																				
Usual Residence of Decedent																					
10a. State Md.		10b. County Anne Arundel Co.		10c. City, Town or Location Pasadena				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
10e. Street and Number 519 Sunset Knoll Road				10f. Zip Code 21122		10g. Citizen of What Country? USA															
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer			16b. Kind of Business/Industry U.S. Government Corp. of Engineers															
17. Father's Name (First, Middle, Last) John Regan					18. Mother's Name (First, Middle, Maiden Surname) Maude Bartlett																
19a. Informant's Name/Relationship (Type, Print) Timothy Regan (Son)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4408 Tonquil Street, Beltsville, Md. 20705																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		Date 6/12/99		20c. Location - City or Town, State Glen Burnie, Md.														
21. Signature of Funeral Service Licensee Christina A. Hilton					22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e.</td> <td>Cardiac arrhythmias</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Cardiac arrest</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Metastatic Prostate cancer</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e.	Cardiac arrhythmias	Due to (or as a consequence of):	b.	Cardiac arrest	Due to (or as a consequence of):	c.	Metastatic Prostate cancer	Due to (or as a consequence of):	d.		
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e.	Cardiac arrhythmias	Due to (or as a consequence of):																		
	b.	Cardiac arrest	Due to (or as a consequence of):																		
	c.	Metastatic Prostate cancer	Due to (or as a consequence of):																		
	d.																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred															
			28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier Dr. Markan M.D.					29c. License number D39505		29d. Date signed (Month, Day, Year) June 9, 1999														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudhishtira Markan 1600 Chain Hwy, Glen Burnie, MD 21061																					
31. Date filed (Month, Day, Year) JUN 11 1999			32. Registrar's Signature B. Sparks																		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

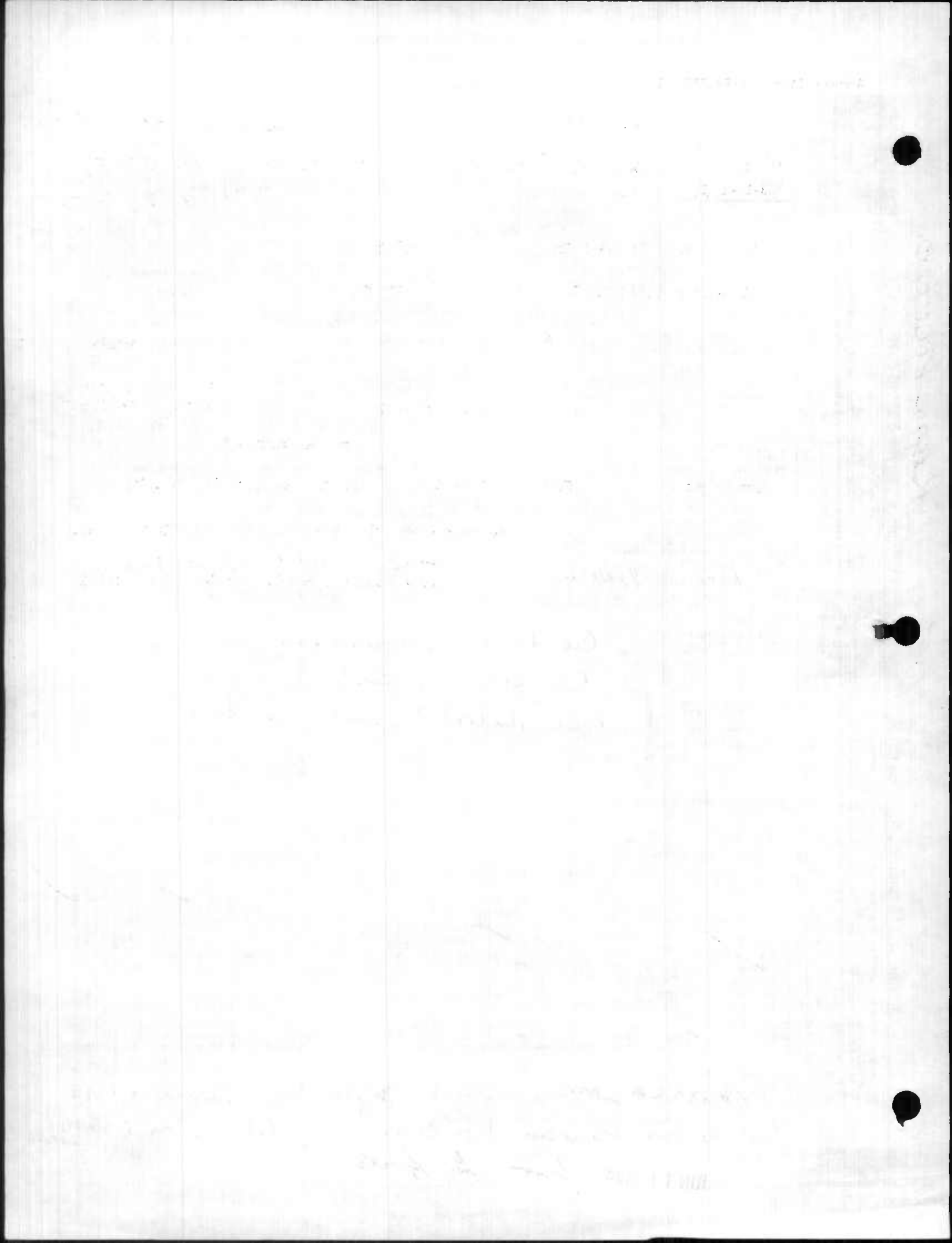
Baltimore, Maryland 21215-0020
Regan Robert B.
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 33a or 33b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18833

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) M. HILDA SMITH		2. Date of Death Month Day Year JUNE 09 1999		3. Time of Death 00:30
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A
Funeral Director	5. Social Security Number 215-24-9924A	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	8. Date of Birth (Month, Day, Year) Jan. 24, 1917	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 706 Gold St.		10f. Zip Code 21217		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+) 0		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Literacy Program		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) James Young		18. Mother's Name (First, Middle, Maiden Surname) Effie Wiggins		
	19a. Informant's Name/Relationship (Type, Print) (niece) Mrs. Anita Cammon		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Monticello Rd, Balto. Md. 21216		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Auburn		20c. Location - City or Town, State Balto. Md.
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216		
	23a. Pertinent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. ATRIAL FIBRILLATION Due to (or as a consequence of): d. PNEUMONIA				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Lawrence MD MEDICINE RESIDENT					
29c. License number RES-000					
29d. Date signed (Month, Day, Year) JUNE 9, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARILYN LAWRENCE 600 NORTH WOLFE STREET, TOWER 110, BALTIMORE, MARYLAND, 21207					
31. Date filed (Month, Day, Year) JUN 11 1999					
32. Registrar's Signature Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18834

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Buyreal Sullivan, Jr.				2. Date of Death Month Day Year June 7, 1999		3. Time of Death 5:30 a.m.		
	4a. Facility Name (If not institution, give street and number) 1336 Greyswood Road				4b. City, Town, or Location of Death Odenton		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 214-46-9559		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) June 1, 1946		
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Odenton 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1336 Greyswood Road		10f. Zip Code 21113		
10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Director of Data Processing		16b. Kind of Business/Industry Trade Association		17. Father's Name (First, Middle, Last) Robert Buyreal sullivan, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Evelyn Margaret Boston	
19a. Informant's Name/Relationship (Type, Print) Diane Sullivan/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1336 Greyswood Road, Odenton, Maryland 21113		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Jenkins Chapel		20c. Location - City or Town, State 6/11/99 Mathias, West Virginia	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707		23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Colon Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 Years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D45014		29d. Date signed (Month, Day, Year) 6/7/99		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Isabella C. Martire, MD 8379 Cherry Lane, Laurel, Maryland 20707	
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 		33. State Registrar State Registrar		34. DHMH 16 Rev 6/95		35. Baltimore, Maryland 21215-0020	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

442071

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18835

AMENDED ITEM #5 PER FH G772 6/11/99 AH

Physician
/Medical
Examiner

Darlene Faith Scherer

2. Date of Death
Month Day Year
June 01, 1999
3. Time of Death
5:05 P.M.

4a. Facility Name (If not institution, give street and number)

Honga River

4b. City, Town, or Location of Death

Fishing Creek

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

216-56-9879

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 26 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Phoenix

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14529 Old York Road

10f. Zip Code

21131

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

n/a

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Hairdresser

16b. Kind of Business/Industry

Cosmetology

17. Father's Name (First, Middle, Last)

Charles Russell Coulbourne

18. Mother's Name (First, Middle, Maiden Surname)

Dolores Katherine Eckert

19a. Informant's Name/Relationship (Type, Print)

Charles D. Scherer/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14529 Old York Rd., Phoenix, MD 21131

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Balto. Wash. Crematory

Date

6/7/99

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

Lowell M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home
10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Drowning
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)
6-1-99

28b. Time of Injury

1520 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject drowned

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Creek

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Fishing Creek
Dorchester Co., Md29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 02, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute, MD

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

Beverly B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18836

AMEND ITEM: #2 PER MD G772 6-24-99 WR.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK D. Scott				2. Date of Death Month Jun Day 9 Year 1999		3. Time of Death 12:05 PM		
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL CONTINUACARE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 215-12-0759		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APRIL 15, 1918	9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
10a. State MARYLAND		10b. County		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Street and Number 5502 S. MEDWICK GARTH				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH GRADE College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CABINET MAKER			16b. Kind of Business/Industry MANUFACTURING		
17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN					
19a. Informant's Name/Relationship (Type, Print) CATHERINE L. SCOTT (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5502 S. MEDWICK GARTH - BALTIMORE, MARYLAND 21228					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC.		Date 6/10/99		20c. Location - City or Town, State BALTIMORE, MARYLAND			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARRHYTHMIA Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. LUNG CARCINOMA - Non-Small Cell Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 30 sec.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC CARDIOMYOPATHY								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Jay Gerstenblith, MD		29c. License number D20728		29d. Date signed (Month, Day, Year) 6/9/99 3:30 P.M.			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAY GERSTENBLITH, M.D.; 3455 WILKENS AVE; BALTIMORE, MD 21229									
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

NAME

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

30+1

State Registrar

For the purpose of the present study, the following data were collected from the various sources mentioned above. The results are presented in the following table.

TABLE I

1

1945

The following table shows the results of the study for the year 1945. The data are presented in the following table.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18837

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ISABELLE

SIMONS

2. Date of Death

Month Day Year
JUNE 08 1999

3. Time of Death

4:10 PM

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL COLUMBIA

4b. City, Town, or Location of Death

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

218-18-0212

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCTOBER 17, 1929

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3600 WEST FRANKLIN STREET

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMECARE

16b. Kind of Business/Industry

AGENCY

17. Father's Name (First, Middle, Last)

RICHARD

18. Mother's Name (First, Middle, Maiden Surname)

ISABELLE LEE

19a. Informant's Name/Relationship (Type, Print)

JOYCE SIMONS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2727 MARBOURNE AVE. BALTO. MD. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS CEMETERY

Date

06-14-99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Respiratory failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

b.

Sepsis

Due to (or as a consequence of):

days

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Shock liver, pneumonia, gastro-intestinal bleed, end stage renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

036845

29d. Date signed (Month, Day, Year)

Jun 08 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5999 HARPERS FARM RD, # W215, COLUMBIA, MD 21044

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

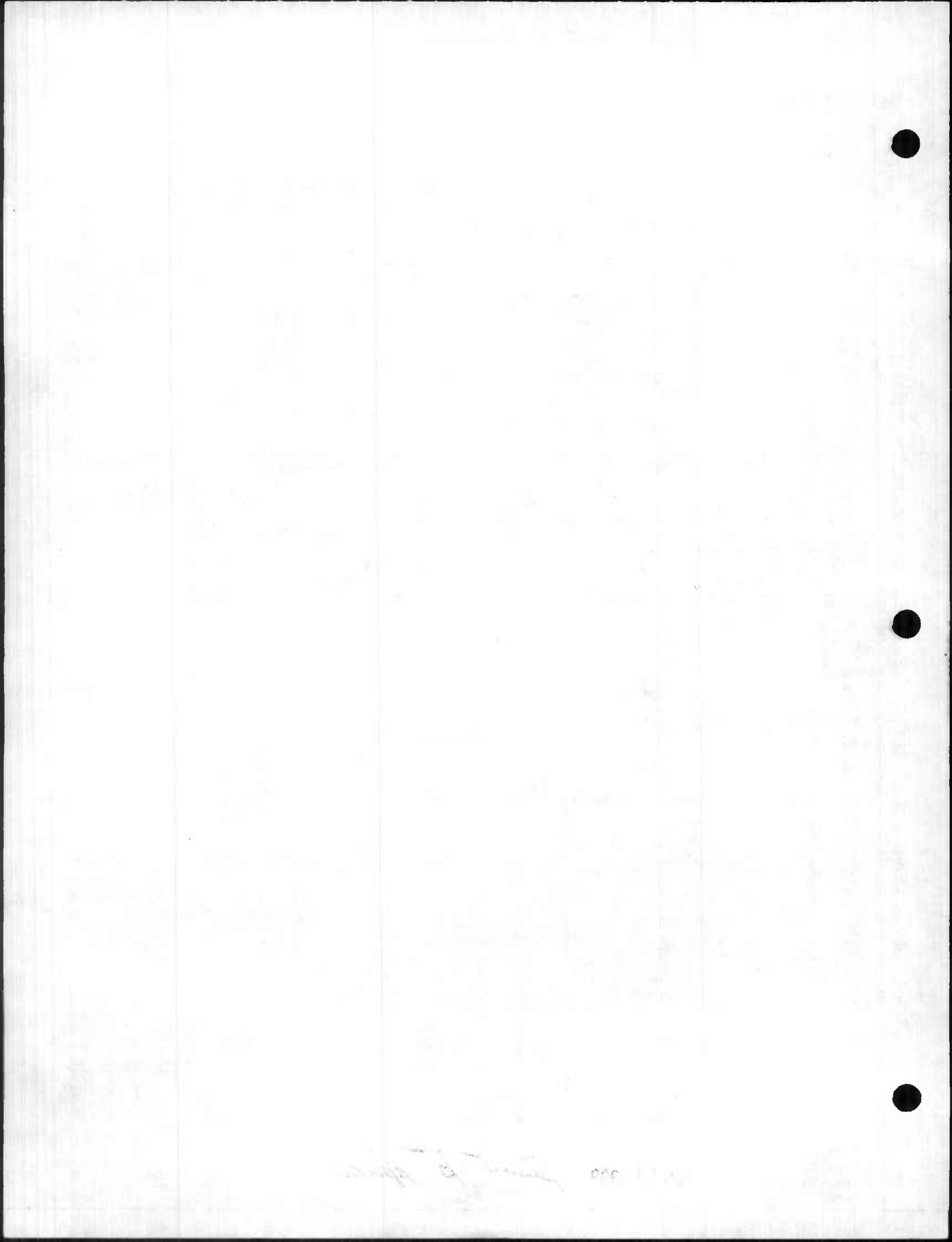
To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18838

RICKEY SUMNER JR.
ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-16-99 WR. **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rickey L. Sumner, Jr.						2. Date of Death Month Day Year JUNE 6, 1999		3. Time of Death 0707 AM	
	4a. Facility Name (If not institution, give street and number) 3315 ELM AVENUE						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-11-2754		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 27 Yrs.		8. Date of Birth (Month, Day, Year) March 26, 1972		9. Birthplace (State or Foreign Country) Baltimore, MD	
	Usual Residence of Decedent									
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Street and Number 3315 Elm Avenue				10f. Zip Code 21211				10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker				16b. Kind of Business/Industry Construction		
17. Father's Name (First, Middle, Last) Rickey L. Sumner, Sr.						18. Mother's Name (First, Middle, Maiden Sumname) Kathy Uhrig				
19a. Informant's Name/Relationship (Type, Print) Kathy Davis Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4004 Taylor Avenue Baltimore, MD 21236						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. Date 6/9/99		20d. Location - City or Town, State Parkville, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211						
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NARCOTIC AND ALCOHOL INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found: 6-6-99		28b. Time of Injury Found: 6:45		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT INGESTED DRUGS AND ALCOHOL		
28a. Place of Injury - At home, term, street, factory, office building, etc. (Specify) FOUND AT RESIDENCE		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3315 ELM AVE. BALTIMORE, MARYLAND								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number O.C.M.E				29d. Date signed (Month, Day, Year) JUNE 7, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18839

ITEM: #24A PER MD G772 6-11-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Loretta Schwartz				2. Date of Death Month Day Year April 3, 1999		3. Time of Death 11:30P	
	4a. Facility Name (If not institution, give street and number) Long Green 115 S Melrose Place				4b. City, Town, or Location of Death Baltimore		4c. County of Death na	
Funeral Director	5. Social Security Number 215-12-2680		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 15, 1919	
	9. Birthplace (State or Foreign Country) Maryland		10. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
10e. Street and Number 115 S. Melrose Place		10f. Zip Code 21212		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown				
17. Father's Name (First, Middle, Last) John Joseph Schwartz				18. Mother's Name (First, Middle, Maiden Surname) Margaret Elizabeth Ervin				
19a. Informant's Name/Relationship (Type, Print) unknown				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) unknown		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Degenerative Joint Disease Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier RAN		29c. License number D 31464		29d. Date signed (Month, Day, Year) 4/19/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SHOAH A. HASHMI, 821 N. Eulan St Suite 308, Balt. Md								
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature Jenna B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#24a²⁶ per PhyG772 6/11/99EW

Certificate of Death

Reg. No.

99 18840

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Esther Dorothy Stiegler				2. Date of Death Month Day Year June 1, 1999		3. Time of Death 8:00 A.M.	
	4a. Facility Name (If not institution, give street and number) 6412 Bonnie Brae Road				4b. City, Town, or Location of Death Eldersburg		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 216-05-0202	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 21, 1914	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Woodstock		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3542 Hernwood Road				10f. Zip Code 21163		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (1-4 or 5+) -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) John Nelson Doyle, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Anna Lillian Muhly				
19a. Informant's Name/Relationship (Type, Print) Ronald W. Stiegler - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6412 Bonnie Brae Road; Eldersburg, Maryland 21784				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Date 6/5/99		20d. Location - City or Town, State Woodlawn, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastric Ulcer Due to (or as a consequence of): b. Dementia Due to (or as a consequence of): c. Abdominal Aortic Aneurism Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Son's Residence						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D 51705		29d. Date signed (Month, Day, Year) 6-3-1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. PANSURINA 419F Malcolm Dr, Westminster MD 21157								
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18841

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEANNETTE SCHEIDT

2. Date of Death

Month Day Year
JUNE 08 1999

3. Time of Death

1:55 pm

4a. Facility Name (If not institution, give street and number)

CHURCH HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

213 16 5737

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jul 29, 1915

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1601 PUMPHREY ST.

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

CHARLES ABELL

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE BURRIER

19a. Informant's Name/Relationship (Type, Print)

DENNIS SCHEIDT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1601 PUMPHREY ST., BALTIMORE, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK

Date

Jun 10 1999

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Kaczorowski

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME

1201 DUNDALK AVENUE, BALTIMORE, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPOXIA
Due to (or as a consequence of):

HOURS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PLEURAL EFFUSION
Due to (or as a consequence of):

DAYS

c. LYMPHOMA
Due to (or as a consequence of):

MONTHS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Francis Chaudian MD

29c. License number

D 42892

29d. Date signed (Month, Day, Year)

JUNE 08 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

90 N BROADWAY # 307

FRANCIS CHAUDIAN

BALTIMORE, MD 21251

State
Registrar

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

Jenna B. Sparks

Baltimore, Maryland 21205-0020 TO PHYSICIAN

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18842

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Spicer				2. Date of Death Month Day Year June 8, 1999				3. Time of Death 12:05AM		
	4a. Facility Name (If not institution, give street and number) 1902 Altavue Road				4b. City, Town, or Location of Death Catonsville				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 214-03-1250		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) Feb. 23, 1912		9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Baltimore		10c. City, Town or Location Woodlawn		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 7602 Clays Lane		10f. Zip Code 21244		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Emmett Young		18. Mother's Name (First, Middle, Maiden Summa) Jane Mullinix			
19a. Informant's Name/Relationship (Type, Print) Kenneth D. Spicer (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Altavue Road, Catonsville, Maryland 21228		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State 6/11/99 Woodlawn, Maryland			
21. Signature of Funeral Service Licensee Robert Gregg Bush		22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Heart Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Daughters Home		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier		29c. License number DS0517	
29d. Data signed (Month, Day, Year) 6/8/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory Burkay MD 1120 N.rolling Road		31. Data filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature Benita B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18844

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CONNIE TSOTTLES		2. Date of Death Month JUNE Day 5 Year 1999		3. Time of Death 15:05m
	4e. Facility Name (If not institution, give street and number) John Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 223-42-0585	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs., last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Jan. 12, 1934		9. Birthplace (State or Foreign Country) Indiana		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County N/A
	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2703 Beechland Avenue		10f. Zip Code 21214		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Emory Mick		18. Mother's Name (First, Middle, Maiden Surname) Betty Robson		
	19a. Informant's Name/Relationship (Type, Print) Mr. Michael Tsottles-Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2703 Beechland Avenue, Baltimore, Md. 21214		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Robson Family Cemetery		20c. Location - City or Town, State 6/9/99 Rixeyville, Virginia
	21. Signature of Funeral Service Licensee Gary R. Di Giovanni		22. Name and Address of Facility Leonard J. Ruck Funeral Home Inc. 5305 Harford Rd. Baltimore, Md. 21214		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) SEPSIS					2 WEEKS
Due to (or as a consequence of): ENTEROCUTANEOUS FISTULA					3 WEEKS
Due to (or as a consequence of): METASTATIC SQUAMOUS CELL CARCINOMA					3 WEEKS
Due to (or as a consequence of):					
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Rafael J. Cousin MD		29c. License number RES-000	29d. Date signed (Month, Day, Year) JUNE 5, 1999
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RAFAEL J. COUSIN 600 NORTH WOLF STREET, BALTIMORE 21287					
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEM: #3 PER MD G772 6-17-99 WR.

99 18843

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA ELIZABETH SIBLEY				2. Date of Death Month JUNE Day 9 Year 1999		3. Time of Death 3:15 PM	
	4a. Facility Name (If not institution, give street and number) 3704 GREENVALE RD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-28-8677		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT 26 1932	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 3704 GREENVALE RD				10f. Zip Code 21229		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REPROGRAPHICS SPECIALIST		16b. Kind of Business/Industry GRAPHICS			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) GEORGE A. WEINKAM				18. Mother's Name (First, Middle, Maiden Surname) EDNA A. CHENOWITH			
	19a. Informant's Name/Relationship (Type, Print) Kenneth E. Sibley/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3704 Greenvale Rd. Baltimore MD 21227			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral		20c. Location - City or Town, State 6/12 Baltimore, MD			
	21. Signature of Funeral Service Licensee Sean P. Suber		22. Name and Address of Facility ARMOR & FUNERAL HOME OF LANSOWNE 2719 HAMMOND FERRY RD LANSOWNE MD 21227					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory Arrest Due to (or as a consequence of): Pulmonary Edema Due to (or as a consequence of): Carcinoid Tumor Due to (or as a consequence of):							Approximate Interval Between Onset and Death 5mch
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier Sally J. Rubenstone MD				29c. License number D50227		29d. Date signed (Month, Day, Year) 6/10/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALLY J. RUBENSTONE 700 GEIPE RD, BALTIMORE, MD 21228							
State Registrar	31. Date filed (Month, Day, Year) JUN 11 1999				32. Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

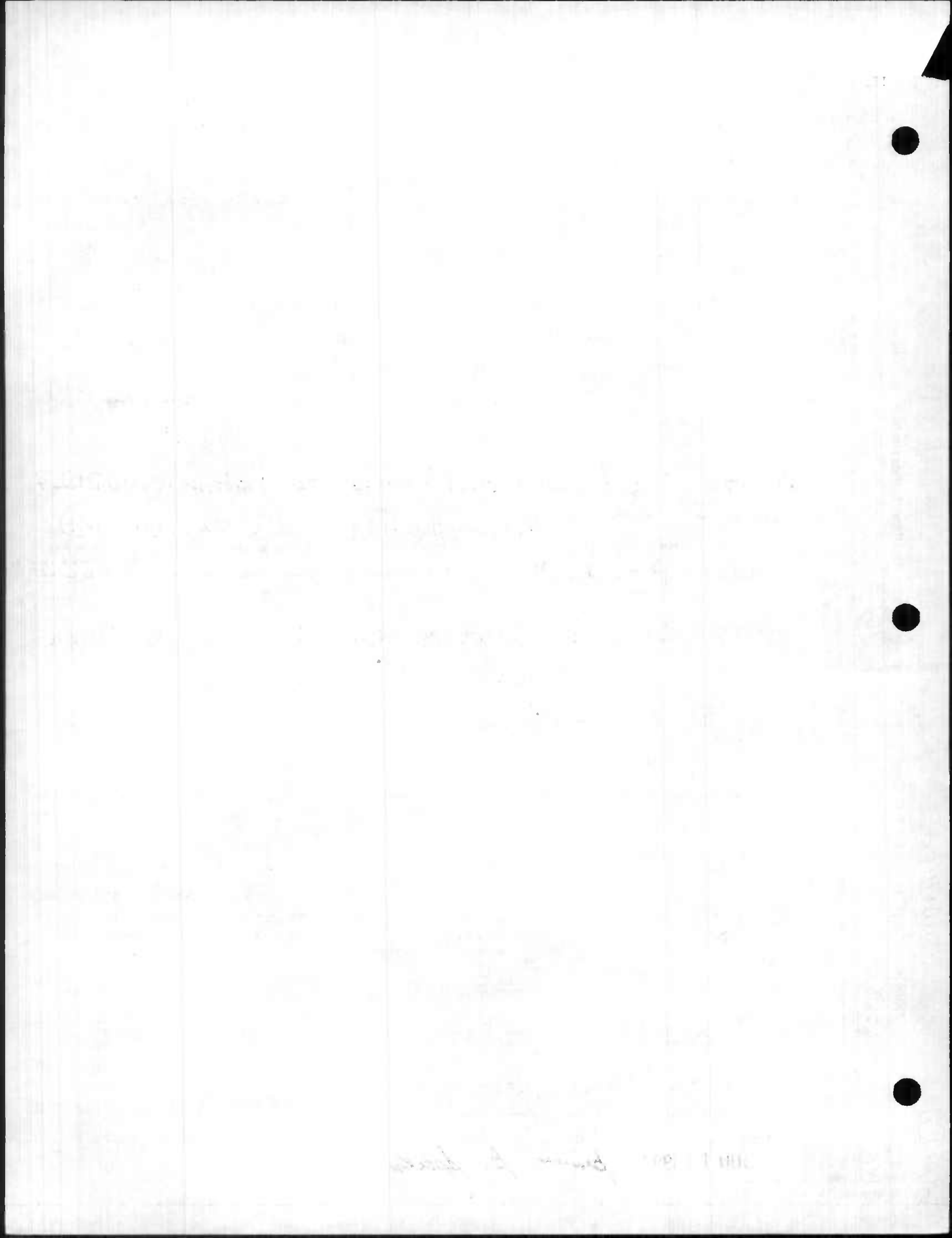
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

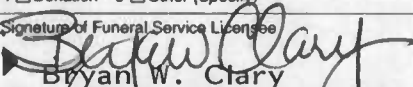
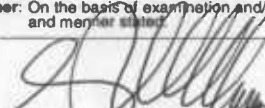


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18845

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Wright - Benson				2. Date of Death Month Day Year June 7 1999		3. Time of Death 9:00 pm		
	4a. Facility Name (If not institution, give street and number) Multi Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 212-03-2833		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) June 8 1900		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Towson		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 7700 York Road		10f. Zip Code 21204		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) n/a		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Proof Reader		16b. Kind of Business/Industry Printing					
17. Father's Name (First, Middle, Last) George Alfred Peters				18. Mother's Name (First, Middle, Maiden Surname) Minnie Irene Bonsal					
19a. Informant's Name/Relationship (Type, Print) John C. Wright/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19301 York Road, Parkton, MD 21120					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Date 6/11/99		20d. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee  Bryan W. Clary		22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. Alzheimers dementia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death > 5yrs	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anorexia / dehydration						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D32939		29d. Date signed (Month, Day, Year) 6/9/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 103 Gregory Pokrywka, M.D. 2914 East Joppa Rd., Balto., MD 21234									
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

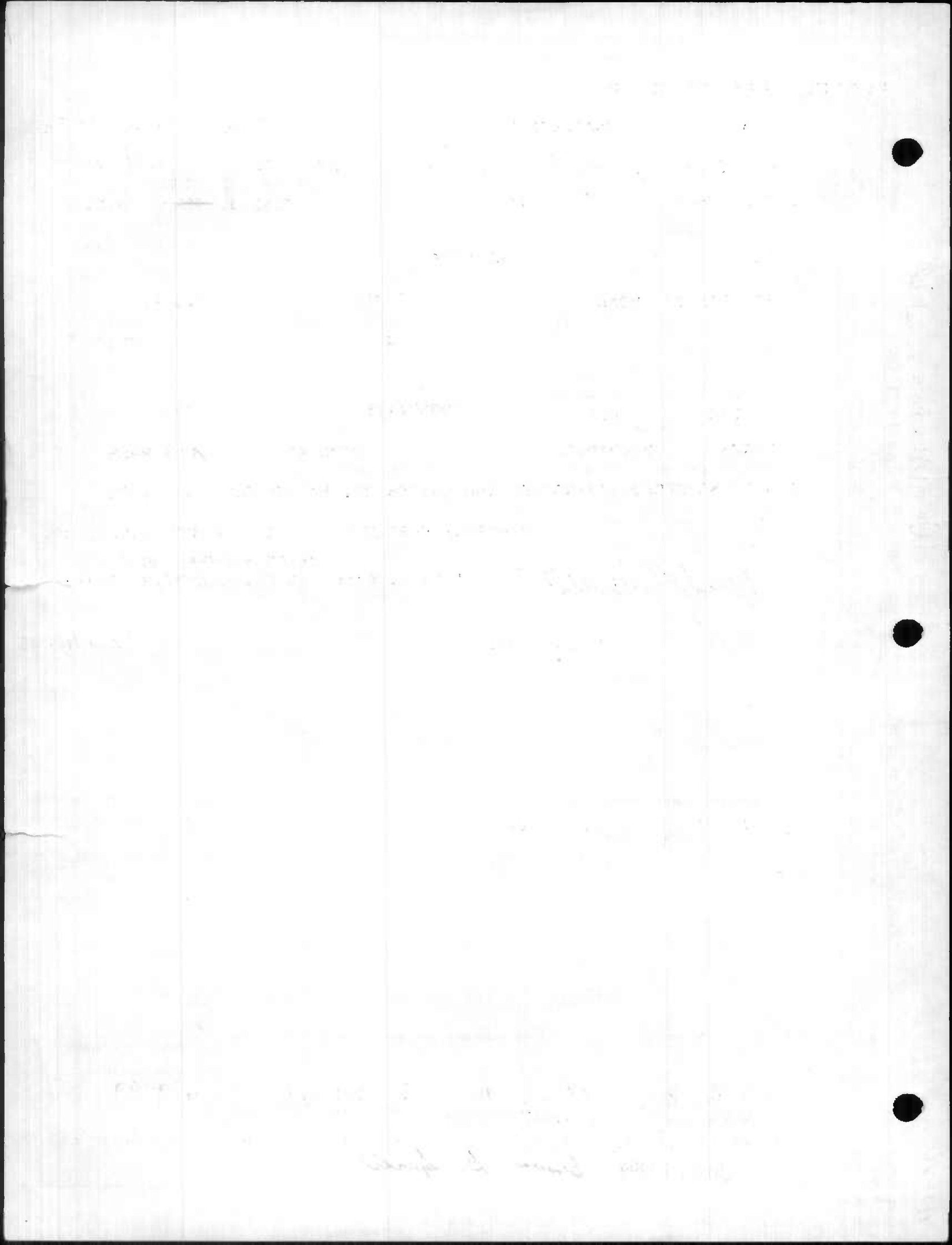
Certificate of Death

99 18846

AMENDED ITEM #8 PER FH G772 6/11/99 AH

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) IDA WEATHERBEE		2. Date of Death Month Day Year June 9 1999		3. Time of Death 2:57 AM
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center		4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 216-20-7579	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	8. Date of Birth (Month, Day, Year) JUNE 3, 1999	9. Birthplace (State or Foreign Country) N.C.
	Usual Residence of Decedant				
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 150 CARVER ROAD		10f. Zip Code 21222	10g. Citizen of What Country? U.S.A.	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH N/A		
To Be Completed by Physician/Medical Examiner	16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry HOME		
	17. Father's Name (First, Middle, Last) AUGUS MCPHERSON		18. Mother's Name (First, Middle, Maiden Surname) DOROTHY MCKINNON		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JOSEPH MCPHERSON, JR/NEPHEW		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 CARVER RD. BALTIMORE, MD. 21222		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VA. 6/15		20c. Location - City or Town, State OWINGS MILLS, MD.
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility BETTS FUNERAL HOME 1129 n. CAROLINE ST. BALTO., MD. 21213		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 24 Hours		
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease Coronary Artery Disease		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> M.D. 29c. License number RD 191726 29d. Date signed (Month, Day, Year) 6/9/99		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr Sapan Mady 9000 Franklin Square Drive Baltimore, Maryland 21237				
State Registrar	31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature <i>[Signature]</i>		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18847

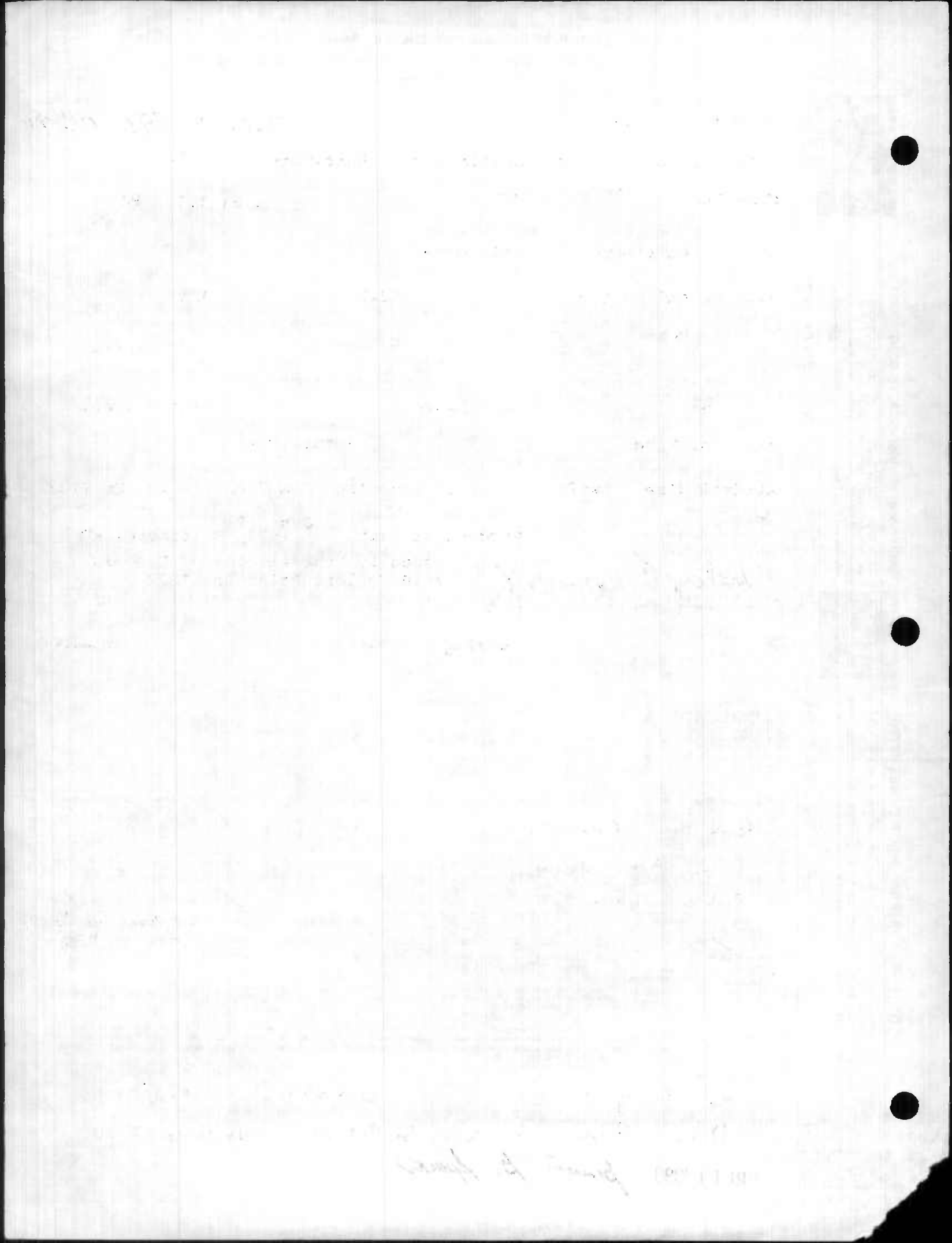
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Samuel Wise				2. Date of Death Month Day Year JUNE 9, 1999				3. Time of Death 10:10 AM						
	4a. Facility Name (If not institution, give street and number) Mercy Medical Center - Stella Maris				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A						
Funeral Director	5. Social Security Number 216-07-3136		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Dec 31 1915		9. Birthplace (State or Foreign Country) PA						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 6729 Graceland Ave				10f. Zip Code 21222		10g. Citizen of What Country? USA								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shearman				16b. Kind of Business/Industry Beth - Steel								
	17. Father's Name (First, Middle, Last) James M. Wise				18. Mother's Name (First, Middle, Maiden Surname) Jennie Frye										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mildred Wise /wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6729 Graceland Ave Baltimore, MD 21222										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		Date June 12 1999		20c. Location - City or Town, State Baltimore, MD								
	21. Signature of Funeral Service Licensee Anthony C. Connelly				22. Name and Address of Facility Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														
	Approximate Interval Between Onset and Death 6 w.m														
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Rubection Pneumonia Coronary Artery Disease Diabetes Mellitus								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
									24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) hospital										
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier Dr. [Signature]		29c. License number D40654		29d. Date signed (Month, Day, Year) 6/9/99	
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) David Rosenberg, MD 301 St Paul Pl Baltimore 21202															
31. Date filed (Month, Day, Year) JUN 11 1999		32. Registrar's Signature [Signature]													

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



99 18848

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Shirley Ruth Betts		2. DATE OF DEATH MONTH DAY YEAR May 31 1999		3. TIME OF DEATH 5:30 P.M.	
4. SOCIAL SECURITY NUMBER 214-32-0972		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.	
7. DATE OF BIRTH (Month, Day, Year) February 13, 1935		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 102 Caroline Apartments, 205 South		9b. CITY, TOWN OR LOCATION OF DEATH Denton		9c. COUNTY OF DEATH Caroline	
10a. STATE Maryland		10b. COUNTY Caroline		10c. CITY, TOWN OR LOCATION Denton	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 102 Caroline Apartments, 205 South 8th St.		10f. ZIP CODE 21629	
10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Food Broker	
17. FATHER'S NAME (First, Middle, Last) Martin Green Betts		18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Rosetta Tull			
19a. INFORMANT'S NAME (Type/Print) Glenna M. Lynch		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cousin 303 Strawberry Court, Ridgely, Maryland 21660			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capitol Crematory		20c. LOCATION — City or Town, State 6/2 Dover, Delaware	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Randolph P. Moore</i>		22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. 21629 12 South Second Street, Denton, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → HYPERTENSIVE CARDIOVASCULAR DISEASE ACUTE					
DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSION					
DUE TO (OR AS A CONSEQUENCE OF): CHRONIC					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christian E. Jensen MD Deputy ME</i>		29c. LICENSE NUMBER D14664		29d. DATE SIGNED (Month, Day, Year) 6/1/99	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Christian E. Jensen, M.D., PO Box 690, Denton, Maryland 21629					
31. DATE FILED (Month, Day, Year) JUN - 3 1999		32. REGISTRAR'S SIGNATURE <i>Bevera B. Sparks</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6. 13. 76



It is a very small bird, about 10 cm long, with a brown back and a white belly. It has a short tail and a small beak. It is very common in the area.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18869

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Betty A. Baker</i>				2. Date of Death Month <i>May</i> Day <i>29</i> Year <i>99</i>				3. Time of Death <i>11:23 A</i>		
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical System</i>				4b. City, Town, or Location of Death <i>Baltimore, MD</i>				4c. County of Death <i>City</i>		
Funeral Director	5. Social Security Number <i>217-36-1598</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>61</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Jan 11 1938</i>		9. Birthplace (State or Foreign Country) <i>Ridgely, MD</i>		
	Usual Residence of Decedent				10a. State <i>Maryland</i>		10b. County <i>Caroline</i>		10c. City, Town or Location <i>Ridgely</i>		
				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>310 Central Ave.</i>		10f. Zip Code <i>21660</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11yrs</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>manager</i>		16b. Kind of Business/Industry <i>video rental indust.</i>			
				17. Father's Name (First, Middle, Last) <i>Woodrow Wilson Pollard</i>				18. Mother's Name (First, Middle, Maiden Summa) <i>Louise Hickman Pollard</i>			
				19a. Informant's Name/Relationship (Type, Print) <i>Joseph A. Baker/ husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P.O. Box 6 Ridgely, Maryland 21660</i>			
				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Ridgely Cemetery</i>		20c. Location - City or Town, State <i>6/2 Ridgely, Maryland</i>			
				21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Fleegle & Helfenbein Funeral Home, PA P.O. Box 160 Greensboro, MD 21639</i>					
				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Hypoxia</i> Due to (or as a consequence of): b. <i>Myocardial infarction</i> Due to (or as a consequence of): c. <i>Coronary artery disease</i> Due to (or as a consequence of): d.							
				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>P12446</i>		29d. Date signed (Month, Day, Year) <i>May 29, 1999</i>			
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>University of Maryland 23 Greene St. Baltimore, MD</i>							
				31. Date filed (Month, Day, Year) <i>JUN - 2 1999</i>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18850

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Olivia Butler				2. Date of Death Month Day Year May 27, 1999		3. Time of Death 3:40 PM	
	4a. Facility Name (If not Institution, give street and number) Shore Nursing & Rehabilitation Ctr.				4b. City, Town, or Location of Death Denton		4c. County of Death Caroline	
Funeral Director	5. Social Security Number 220-01-2360		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 9, 1921	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Caroline		10c. City, Town or Location Preston	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4153 Harmony Road		10f. Zip Code 21655		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker		16b. Kind of Business/Industry Canning Houses			
	17. Father's Name (First, Middle, Last) Elbert R. Butler				18. Mother's Name (First, Middle, Maiden Surname) Lillie B. Adams			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) M. Diann Beulah/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 160 Nottingham Dr., Willingboro, NJ 08046			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Pleasant Cemetery		20c. Location - City or Town, State 6/1/99 Preston, Maryland		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Michael F. Eskew				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma unknown primary Due to (or as a consequence of): with hepatic metastases Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 54
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis Renal insufficiency							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier [Signature]
To Be Completed by Physician/Medical Examiner	29c. License number D 35284		29d. Date signed (Month, Day, Year) 5/27/99					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREA AUBIN no 214 So. Washington St Easton MD 21601							
State Registrar	31. Date filed (Month, Day, Year) JUN - 2 1999		32. Registrar's Signature [Signature]					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18851

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Viola Prattis Brummell						2. Date of Death Month Day Year May 28, 1999		3. Time of Death 3:22 PM											
	4e. Facility Name (If not institution, give street and number) Holy Cross Hospital						4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery											
Funeral Director	5. Social Security Number 220-03-8422		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Sep. 10, 1911		9. Birthplace (State or Foreign Country) Delaware											
	Usual Residence of Decedent																			
10e. State MD		10b. County Caroline		10c. City, Town or Location Federalsburg				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
10e. Street and Number 26490 Three Bridges Road				10f. Zip Code 21632		10g. Citizen of What Country? United States														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home													
17. Father's Name (First, Middle, Last) Herbert Prattis						18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Hammond														
19a. Informant's Name/Relationship (Type, Print) Charles Brummell, Jr./Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 283, Federalsburg, MD 21632														
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Federal Hill Cemetery 6/5		Date 6/5		20c. Location - City or Town, State Federalsburg, MD												
21. Signature of Funeral Service Licensee M. F. Gasker				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Cardiac Arrhythmia</td> <td rowspan="4"> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death </td> </tr> <tr> <td>b.</td> <td>Severe Cardiomyopathy</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Cardiac Arrhythmia	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.	Severe Cardiomyopathy	c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Cardiac Arrhythmia	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death																
	b.	Severe Cardiomyopathy																		
	c.																			
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown												
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number D45285																
29b. Signature and title of certifier William J. Ninala				29d. Date signed (Month, Day, Year) May 29, 1999																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WF Ninala, 344 University Blvd #113, Silver Spring, Md.																				
31. Date filed (Month, Day, Year) JUN - 2, 1999				32. Registrar's Signature B. Sparks																

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18852

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Paul BEAVER				2. Date of Death Month Day Year May 23. 1999		3. Time of Death 9:00 am	
	4a. Facility Name (If not institution, give street and number) Glade Valley Nursing & Rehabilitation Ctr				4b. City, Town, or Location of Death Walkersville		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 162-12-6271		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Dec 13, 1918	
	9. Birthplace (State or Foreign Country) Pennsylvania		10. Usual Residence of Decedent 10a. State: Maryland 10b. County: Frederick 10c. City, Town or Location: Frederick 10d. Inside City Limits: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6856 Snowberry Court		10f. Zip Code 21703	
To Be Completed by Funeral Director	10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1943-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Asst Superintendent		16b. Kind of Business/Industry Government (Federal) Printing Office	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Henry I BEAVER				18. Mother's Name (First, Middle, Maiden Surname) Mary Florentine WEBB			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Penny F. Stakes/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1548 St. Lawrence Court, Frederick, Maryland 21701			
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fishertown Cemetery May 26, 1999		20c. Location - City or Town, State Fishertown, Pennsylvania		21. Signature of Funeral Service Licensee Kathleen K. Beaver MO0706	
	22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart Failure Due to (or as a consequence of): 30 day b. Aspiration pneumonia Due to (or as a consequence of): 3 day c. Anemia Due to (or as a consequence of): d. Sequester list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure (insufficiency) Diabetes type II				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number D51643		29d. Date signed (Month, Day, Year) 5/24/99	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 170 Thomas Johnson Drive #100 Frederick MD 21703		31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18853

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Missouri Brown

2. Date of Death

Month

Day

Year

May

22

1999

3. Time of Death

10:10 PM

4a. Facility Name (If not Institution, give street and number)

Reeders Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

212-72-5062

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept 5 1913

9. Birthplace (State or Foreign Country)

Williamsport MD

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

319 A Street

10f. Zip Code

21716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

John Thomas Shank

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Hawbaker

19a. Informant's Name/Relationship (Type, Print)

Delmar V. Brown, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

201 N. Dayton Avenue, Brunswick, MD 21716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Memorial Gardens 5/25

Date

20c. Location - City or Town, State

Frederick, MD

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home
100 Petersville Rd Brunswick MD 21716

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GASTRO-INTESTINAL BLEEDING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBRO VASCULAR DISEASE

ATRIAL FIBRILLATION

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Zubair Syed

29c. License number

D52055

29d. Date signed (Month, Day, Year)

5-23-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zubair Syed 130 West High Street, Hancock, Maryland 21750/301-678-7250

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

[Signature]

Name: Mary Missouri Brown
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18854

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Ralph Henry BLANK

2. Date of Death

May 21, 1999

3. Time of Death

10:58 PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

218-10-9568

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 5, 1920

9. Birthplace (State or Foreign)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8441 Edgewood Church Road

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1941-194513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Brick-Stone Mason

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Wilfred Guy BLANK

18. Mother's Name (First, Middle, Maiden Surname)

Effie Virginia DELAUTER

19a. Informant's Name/Relationship (Type, Print)

Mrs. Gloria Blank, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8441 Edgewood Church Road, Frederick, Md. 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resthaven Memorial Gardens, May 26, 1999 Frederick, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Richard E. [Signature] MO0255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home
106 East Church St., Frederick, Md. 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause in each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Multi-Organ Failure

Due to (or as a consequence of):

b. Left Hip Fracture

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d. Pulmonary Edema

Approximate
Interval Between
Onset and Death

Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

IDDM, COPD, CHF

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)

May 12, 1999

28b. Time of
Injury

945 p M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

Fell while walking

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Nursing Home

28f. Location (Street and Number or Rural Route Number,
City or Town, State)200 East 16th St
Frederick, Maryland29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

[Signature]

29c. License number

D35164

29d. Date signed (Month, Day, Year)

May 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene 99 18855

Certificate of Death

Reg. No.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
	DEMAR ELAINE COPPER		APRIL 24, 1999		4:30 a.m.	
Funeral Director	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
	107 GLENWOOD AVE		EASTON		TALBOT	
To Be Completed by Funeral Director	5. Social Security Number	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
	214-34-7788		63	JULY 17, 1935	MD.	
To Be Completed by Physician/Medical Examiner	10e. State		10b. County		10c. City, Town or Location	
	MD.		TALBOT		EASTON	
To Be Completed by Physician/Medical Examiner	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
	107 GLENWOOD AVE.		21601		U.S.A.	
To Be Completed by Physician/Medical Examiner	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
	1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
	Elementary/Secondary (0-12) 12		College (1-4or 5+) ENVIRONMENTAL SERVICES		HOSPITAL	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
	WENDELL MURRAY		ROSIE LENAR TURNER			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
	WALTER COPPER/ HUSBAND		107 GLENWOOD AVE. EASTON, MD. 21601			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
	1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		RICHARDS MEM. PRK 4/29/99		EASTON, MD.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee		22. Name and Address of Facility			
	Evel Dashiell		DASHIELL FUNERAL SERVICES 319 E. DOVER ST. EASTON, MD. 21601			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Chronic renal failure Due to (or as a consequence of): DIABETES MELLITUS b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					2 mo 10 YEARS
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death?
	Diabetes mellitus Organic mental syndrome					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner?		26. Place of Death (Check only one)			
	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	
	1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work?		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one)					29c. License number
	1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29d. Date signed (Month, Day, Year)
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier					29d. Date signed (Month, Day, Year)
	Lawrence D. Bohan, MD					4.26.99
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
	LAWRENCE D. BOHAN, MD 606 DUTCHMANS LANE EASTON, MD. 21601					
State Registrar	31. Date filed (Month, Day, Year)		32. Registrar's Signature			
	APR 26 1999		B. Spahr			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document is a list of the names of the members of the committee.

2. The second part of the document is a list of the names of the members of the committee.

3. The third part of the document is a list of the names of the members of the committee.

4. The fourth part of the document is a list of the names of the members of the committee.

5. The fifth part of the document is a list of the names of the members of the committee.

6. The sixth part of the document is a list of the names of the members of the committee.

7. The seventh part of the document is a list of the names of the members of the committee.

8. The eighth part of the document is a list of the names of the members of the committee.

9. The ninth part of the document is a list of the names of the members of the committee.

10. The tenth part of the document is a list of the names of the members of the committee.

11. The eleventh part of the document is a list of the names of the members of the committee.

12. The twelfth part of the document is a list of the names of the members of the committee.

13. The thirteenth part of the document is a list of the names of the members of the committee.

14. The fourteenth part of the document is a list of the names of the members of the committee.

15. The fifteenth part of the document is a list of the names of the members of the committee.

16. The sixteenth part of the document is a list of the names of the members of the committee.

Unknown 99-119

MARIA ISABEL RODRIQUEZ CONTRERAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18856

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIA ISABEL RODRIQUEZ CONTRERAS				2. Date of Death Month Day Year May 27, 1999		3. Time of Death 4:03 P.M.	
	4a. Facility Name (If not institution, give street and number) University of Maryland, Shock Trauma				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number None		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 27, 1961	
	9. Birthplace (State or Foreign Country) Mexico		10a. State DE		10b. County Sussex		10c. City, Town or Location Seaford	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 900 Easter Lane		10f. Zip Code 19973		10g. Citizen of What Country? Mexico	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Mexican		14. Race - American Indian, Black, White, etc. Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Carlos Contreras				18. Mother's Name (First, Middle, Maiden Surname) Susana Rodriguez			
	19a. Informant's Name/Relationship (Type, Print) Carlos Velazco/Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Easter Lane, Seaford, DE 19973			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Zacatepec Cemetery		20c. Location - City or Town, State Zacatepec, Mexico		20d. Date	
	21. Signature of Funeral Service Licensee Michael F. Eskow				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Head Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 5/20/99		28b. Time of Injury 1233 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street		28d. Describe how injury occurred motor vehicle collision		28f. Location (Street and Number or Rural Route Number, City or Town, State) Powellville Road, Sykesburg, Maryland			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and Title of certifier Dennis J. Chutkan				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) May 28, 1999	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chutkan 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) JUN 8 1999				32. Registrar's Signature Bruce B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner


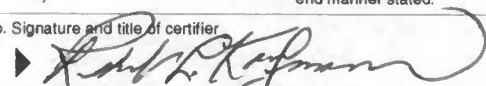

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18857

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paul William Dorsey				2. Date of Death Month May Day 21 Year 1999		3. Time of Death 11:15am		
	4a. Facility Name (If not institution, give street and number) College View Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 218-16-2090		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 20, 1920 Md.		
	10e. State Md.		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 800 Motter Avenue				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) 6th		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sanitary Worker/Truck Driver		16b. Kind of Business/Industry Sanitation Company				
	17. Father's Name (First, Middle, Last) Richard H. Dorsey				18. Mother's Name (First, Middle, Maiden Surname) Annie M. Dunnmark				
	19a. Informant's Name/Relationship (Type, Print) Mary Ann Dorsey				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Motter Ave. Frederick, Md. 21701				
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forrest Cem. Owings Mills, Md.		Date May 28, 1999		20c. Location - City or Town, State Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gary L. Rollins Funeral Home 110 West South Street, Frederick, Md. 21701				
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cong. Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	23f. Approximate Interval Between Onset and Death 2 yrs								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D-13971		29d. Date signed (Month, Day, Year) 5/24/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 W 9th St Frederick MD 21701									
31. Date filed (Month, Day, Year) MAY 27 1999				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18858

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anthony Dipple				2. Date of Death Month Day Year May 26, 1999		3. Time of Death 9:40 a.m.		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 216-80-1719		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 9, 1940		
	9. Birthplace (State or Foreign Country) England		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6405 Kelly Court		10f. Zip Code 21703		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cancer Research Scientist		16b. Kind of Business/Industry Frederick Cancer Research Center		17. Father's Name (First, Middle, Last) William Dipple		18. Mother's Name (First, Middle, Maiden Summa) Nellie Thorpe	
19a. Informant's Name/Relationship (Type, Print) Joanne Jewell/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 10400 B Barretts Delight Dr., Cockeysville, MD		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Location - City or Town, State 5/30/99 Hagerstown, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Homes, P.A.		22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiac Arrhythmia Coronary Artery Disease		Approximate Interval Between Onset and Death minutes years	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Insufficiency Renal Transplant		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 029591		29d. Date signed (Month, Day, Year) 5/27/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mark P. Rubin, 201 Thomas Johnson Drive, Frederick, Maryland 21702		31. Date filed (Month, Day, Year) MAY 28 1999		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 18859

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMILY TINNEY DARBY

2. Date of Death

Month Day Year
MAY 23 1999

3. Time of Death

3:47 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Northampton Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

214-10-4066

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 2 1919

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Beallsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

19811 Darnestown Road

10f. Zip Code

20839

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☐ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

James Patrick Tinney

18. Mother's Name (First, Middle, Maiden Surname)

Anne E. Shelton

19a. Informant's Name/Relationship (Type, Print)

Harry D. Darby/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 742 Beallsville, MD 20839

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Monocacy Cemetery

Date

5/27

20c. Location - City or Town, State

Beallsville, MD

21. Signature of Funeral Service Licensee

Will C. Hill

22. Name and Address of Facility

Hilton Funeral Home 20838
22111 Beallsville Rd. Barnesville, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Breast cancer
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of Certifier

J.P. Henry MD 9th Ave

29c. License number

D35553

29d. Date signed (Month, Day, Year)

May 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.P. Henry MD 9th Ave Brunswick MD 21746

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

J.P. Henry

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
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once.Physician
/Medical
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18860

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carol Lynn DEVILBISS				2. Date of Death Month May Day 23 Year 1999		3. Time of Death 11:28 am	
	4a. Facility Name (If not institution, give street and number) 7730-B Sundays Lane				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 216-48-7187		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 24, 1946	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 7730-B Sundays Lane				10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary/Treasurer			16b. Kind of Business/Industry Construction Company		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Elbert Sanders CHEEKS				18. Mother's Name (First, Middle, Maiden Surname) Shirley CADELL			
	19a. Informant's Name/Relationship (Type, Print) Joseph F. Devilbiss, Sr., Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7730-B Sundays Lane, Frederick, Md. 21702			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lewistown Cemetery, May 27, 1999		Date May 27, 1999		20c. Location - City or Town, State Lewistown, Maryland	
	21. Signature of Funeral Service Licensee Richard E. Gray M00255		22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Traumatic Head Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death Immediate
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Farm					
State Registrar	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) May 23, 1999		28b. Time of Injury 11:28 aM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred tractor over-turned on victim		28e. Location (Street and Number or Rural Route Number, City or Town, State) 7730-B Sundays Ln Frederick, Maryland					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Andrew Zarick, Jr.				29c. License number D35164		29d. Date signed (Month, Day, Year) May 24, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Zarick, Jr., MD, 1080 West Patrick Street, Frederick, Maryland 21703								
31. Date filed (Month, Day, Year) MAY 25 1999				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18861

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Ambrose Ferris

2. Date of Death
Month Day Year

May 27, 1999

3. Time of Death

2:55 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

060-18-3770

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 25, 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5594 Dover Court

10f. Zip Code

21703

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

builder

16b. Kind of Business/Industry

self-employed

17. Father's Name (First, Middle, Last)

William Ferris

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Pepper

19a. Informant's Name/Relationship (Type, Print)

Lois Ferris/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5594 Dover Court, Frederick, MD 21703

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Cemetery

Date

6/1/99

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

D. B. Mack

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 1/2 hours

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Boyd A. Dwyer MD

29c. License number

D37501

29d. Date signed (Month, Day, Year)

5/27/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BOYD A. DWYER MD 801 TOWN HOUSE AVE BLDG H-6 FREDERICK, MD 21701

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

S. B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18862

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Harriett P. Fives
2. Date of Death Month Day Year May 25 1999
3. Time of Death 7:03pm

Funeral
Director

4a. Facility Name (If not institution, give street and number) Glade Valley Nursing Home
4b. City, Town, or Location of Death Walkersville
4c. County of Death Frederick

5. Social Security Number 224-72-6438
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 79 Yrs.
8. Date of Birth (Month, Day, Year) Sept, 19, 1919
9. Birthplace (State or Foreign Country) New Jersey

Usual Residence of Decedent
10a. State Maryland
10b. County Frederick
10c. City, Town or Location Monrovia
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 4983 Linganore Woods Drive
10f. Zip Code 21770
10g. Citizen of What Country? United States

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife
16b. Kind of Business/Industry Own Home

17. Father's Name (First, Middle, Last) Harry Wilson
18. Mother's Name (First, Middle, Maiden Surname) Lilly Canary

19e. Informant's Name/Relationship (Type, Print) Kathleen A. Wilkinson/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4983 Linganore Woods Drive, Monrovia, Md 21770

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Palm Cemetery
20c. Location - City or Town, State Winter Park, Florida

21. Signature of Funeral Service Licensee Olin L. Molesworth
22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) e. Aspiration Pneumonia
Dua to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Parkinson's Disease
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.
Approximate Interval Between Onset and Death Days Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23b. Did tobacco use contribute to this cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24e. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29b. Signature and title of certifier M. T. Moore MD
29c. License number MD051610
29d. Date signed (Month, Day, Year) 5-26-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475 Taney Ave, Frederick, MD 21702

31. Date filed (Month, Day, Year) MAY 28 1999
32. Registrar's Signature [Signature]

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18863

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Theresa Mary GRUNING				2. Date of Death Month May Day 23 , Year 1999		3. Time of Death 7:59pm	
4a. Facility Name (If not institution, give street and number) 10008 Old National Pike				4b. City, Town, or Location of Death Ijamsville		4c. County of Death Frederick	
5. Social Security Number 202-30-6192		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar 21, 1941	
9. Birthplace (State or Foreign Country) Pennsylvania							
Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Ijamsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 10008 Old National Pike				10f. Zip Code 21754		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper/Accounting		16b. Kind of Business/Industry Construction EGS Inc	
17. Father's Name (First, Middle, Last) Michael McANDREW				18. Mother's Name (First, Middle, Maiden Surname) Ann WANALISTA			
19a. Informant's Name/Relationship (Type, Print) Barbara Gallagher/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12520 Saint James Road, Rockville MD 20850			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Heffner Crematory		Date May 29, 1999		20c. Location - City or Town, State York, Pennsylvania	
21. Signature of Funeral Service Licensee <i>Keeney & Basford P.A. Funeral Home</i> MO0706				22. Name and Address of Facility 106 East Church St, Frederick, Maryland 21701			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death Years							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deep Venous Thrombosis						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Michael A. Tolino M.D.</i>				29c. License number D51610		29d. Date signed (Month, Day, Year) May 24, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Tolino, M.D., 1475 Taney Avenue, #204, Frederick, Maryland 21702-5127							
31. Date filed (Month, Day, Year) MAY 25 1999				32. Registrar's Signature <i>B. Sparks</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

Gibson, Jessie

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #5

6/4/99, ldb, Dorchester County

Certificate of Death

Reg. No.

99 18864

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JESSIE ELEANOR GIBSON

2. Date of Death

Month

Day

Year

MAY

27

1999

3. Time of Death

1:37p

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

218-16-5503

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

DEC. 19, 1915

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

605 BAKER STREET

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

OTTIE W. RUARK

18. Mother's Name (First, Middle, Maiden Surname)

ALICE FLOWERS

19a. Informant's Name/Relationship (Type, Print)

MABEL R. HURLEY/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

204 EAST APPLEBY AVENUE, CAMBRIDGE, MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

PARSONS CEMETERY

Date

6/2/99

20c. Location - City or Town, State

SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 3171,
1212 OLD OCEAN CITY ROAD, SALISBURY, MD 2180223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. Use only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

24 hrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

senile dementia

prior subdural hematoma

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending2 ☐ Accident

investigation

3 ☐ Suicide6 ☐ Could not be4 ☐ Homicide

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30853

29d. Date signed (Month, Day, Year)

5/27/99

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Charles B. Silva Jr MD

PRMC

Salisbury MD 21801

31. Date filed (Month, Day, Year)

JUN 1 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-343-2000.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18865

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Elma C. Kessell				2. Date of Death Month Day Year May 27, 1999				3. Time of Death 9:05 A.M.			
4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick			
5. Social Security Number 220-16-0258		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77		8. Date of Birth (Month, Day, Year) Nov. 8, 1921		9. Birthplace (State or Foreign Country) Virginia			
Usual Residence of Decedent											
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Woodsboro				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 10918 Green Valley Road				10f. Zip Code 21798				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) :				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Leroy Whetzel						18. Mother's Name (First, Middle, Maiden Surname) Minnie Catherine Runion					
19a. Informant's Name/Relationship (Type, Print) Diana B. Luck - Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9112 Gue Road, Damascus, Maryland 20872					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hyattstown Methodist		Date 5/31/99		20c. Location - City or Town, State Clarksburg, Maryland			
21. Signature of Funeral Service Licensee ▶ Anne L. Williams				22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0111							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration pneumonia Due to (or as a consequence of): 5 Days b. Congestive heart failure Due to (or as a consequence of): 6 days c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Coronary artery disease Hypertension											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier ▶ Shah. Hirenkumar				29c. License number D51643				29d. Date signed (Month, Day, Year) 5/27/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 170 Thomas Johnson Drive #100 Frederick MD 21702											
31. Date filed (Month, Day, Year) MAY 28 1999				32. Registrar's Signature B. Sparks							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18866

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Marcellus KEMP				2. Date of Death Month Day Year May 24, 1999		3. Time of Death 0945	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 216-14-6035		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 22, 1907	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				10c. City, Town or Location Frederick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. State Maryland		10b. County Frederick		10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
10e. Street and Number 104 West College Terrace		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1942 to 1946 If Yes, Give Year or Dates: 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Banker		16b. Kind of Business/Industry Banking		
17. Father's Name (First, Middle, Last) Harrison Monroe Kemp				18. Mother's Name (First, Middle, Maiden Surname) Marcella Kelly				
19a. Informant's Name/Relationship (Type, Print) Isabelle P. Kemp/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 West College Terrace, Frederick, Md. 21701				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State Frederick, Md. 21701		Date May 27, 1999
21. Signature of Funeral Service Licensee Richard C. Basford				22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death 1 year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Melanoma parotid gland				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier Austin Pearre, Jr.				29c. License number D09689		29d. Date signed (Month, Day, Year) May 27, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Austin Pearre, Jr., M.D., 300 West Ninth Street, Frederick, Md. 21701								
31. Date filed (Month, Day, Year) MAY 28 1999				32. Registrar's Signature B. Sparks				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18867

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy M. King				2. Date of Death Month May Day 23 , Year 1999		3. Time of Death 6:00 AM										
	4e. Facility Name (If not institution, give street and number) 22600 Clarksburg Road				4b. City, Town, or Location of Death Boyd		4c. County of Death Montgomery										
Funeral Director	5. Social Security Number 218-56-3596		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 22, 1906										
	9. Birthplace (State or Foreign Country) Maryland																
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Boyd		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	10e. Street and Number 22600 Clarksburg Road				10f. Zip Code 20841		10g. Citizen of What Country? U.S.A.										
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home.												
	17. Father's Name (First, Middle, Last) John Thomas Mullineaux				18. Mother's Name (First, Middle, Maiden Surname) Lucy B. Brandenburg												
	19a. Informant's Name/Relationship (Type, Print) John R. King, Jr. - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22600 Clarksburg Road, Boyd, Maryland 20841												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Damascus Methodist Cem.		20c. Location - City or Town, State 5/26/99 Damascus, Maryland												
	21. Signature of Funeral Service Licensee <i>Olin L. Molesworth</i>				22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>congestive heart failure</td> <td rowspan="4"> Approximate Interval Between Onset and Death years years </td> </tr> <tr> <td>b.</td> <td>hypertension</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	congestive heart failure	Approximate Interval Between Onset and Death years years	b.	hypertension	c.		d.
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	congestive heart failure	Approximate Interval Between Onset and Death years years														
	b.	hypertension															
	c.																
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier <i>John R. Melnick MD</i>				29c. License number D19294		29d. Date signed (Month, Day, Year) May 24, 1999											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John R. Melnick, M.D. 911 Russell Avenue, Gaithersburg, Maryland 20879																	
31. Date filed (Month, Day, Year) MAY 25 1999		32. Registrar's Signature <i>Benjamin P. Sparks</i>															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18868

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward Charles KONESKI				2. Date of Death Month Day Year MAY 19, 1999		3. Time of Death 2117 PM								
	4a. Facility Name (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				4b. City, Town, or Location of Death PRINCE FREDERICK		4c. County of Death CALVERT								
Funeral Director	5. Social Security Number 102-12-2298		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sep 27, 1921		9. Birthplace (State or Foreign Country) New York						
	Usual Residence of Decedent														
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Lothian				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 247 "B" Street, Lyons Creek Park				10f. Zip Code 20711		10g. Citizen of What Country? U.S.A.									
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1942- If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pipe Fitter			16b. Kind of Business/Industry Construction								
17. Father's Name (First, Middle, Last) Ignatius KONESKI				18. Mother's Name (First, Middle, Maiden Surname) Agnes OLIENTKI											
19a. Informant's Name/Relationship (Type, Print) Rose Mary Lindsay/Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 Walnut Court, Martinsburg, WV 25401											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem Gardens		Date May 26, 1999		20c. Location - City or Town, State Frederick, Maryland							
21. Signature of Funeral Service Director <i>William Robert</i> M00706				22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Hypertensive Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier <i>Theodore M. King</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 21, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Theodore M. King</i> 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) MAY 25 1999				32. Registrar's Signature <i>B. Sparks</i>											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18869

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Irene Ann Nutaites

2. Date of Death

May 26, 1999

3. Time of Death

2:30 p.m.

4a. Facility Name (If not Institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

197-05-9548

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 13, 1913

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

30 North Place

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembly Line

16b. Kind of Business/Industry

Toy Factory

17. Father's Name (First, Middle, Last)

Alex

Nutaites

18. Mother's Name (First, Middle, Maiden Surname)

Agnes

Pitcavig

19a. Informant's Name/Relationship (Type, Print)

Carol A. Mills, Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4899 Blue Spruce Lane, Frederick, Md. 21703

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory, May 27, 1999

Date

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Richard E. Hrap

MO0255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home

106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Septic Shock - Hypotension

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

f.

Septicemia

Due to (or as a consequence of):

48 hours

g.

Urinary Tract Infection

Due to (or as a consequence of):

Days

h.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William H. Johnson MD

29c. License number

D47556

29d. Date signed (Month, Day, Year)

5/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Johnson MD, 187 THOMAS JOHNSON DRIVE, FREDERICK, MD 21702

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

B. Spaul

State
Registrar

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 18870

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald Crozier Noble				2. Date of Death Month 23, 1999 Year		3. Time of Death 9:10 pm														
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick														
Funeral Director	5. Social Security Number 514-50-6096		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 15, 1946														
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Middletown														
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3223 Old National Pike		10f. Zip Code 21769		10g. Citizen of What Country? United States														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Locomotive Engineer		16b. Kind of Business/Industry AmTrak																
	17. Father's Name (First, Middle, Last) Albert R. Noble				18. Mother's Name (First, Middle, Maiden Surname) Rebecca Crozier																
	19a. Informant's Name/Relationship (Type, Print) Linda Noble / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3223 Old National Pike, Middletown, MD 21769																
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Christ Reformed Cemetery		20c. Location - City or Town, State Middletown, MD		20d. Date 5/27/99														
	21. Signature of Funeral Service Licensee D. P. H. H. H.				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Acute Myocardial Infarction</td> <td>Approximate Interval Between Onset and Death 24 hours</td> </tr> <tr> <td>b.</td> <td>Coronary Artery Disease</td> <td>10 years</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Acute Myocardial Infarction	Approximate Interval Between Onset and Death 24 hours	b.	Coronary Artery Disease	10 years	c.			d.		
	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Acute Myocardial Infarction	Approximate Interval Between Onset and Death 24 hours																	
b.		Coronary Artery Disease	10 years																		
c.																					
d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																					
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
29b. Signature and title of certifier Ed. P. Riuli		29c. License number D36649		29d. Date signed (Month, Day, Year) 5/23/99																	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Edward P. Riuli, 310 W. 9th Street, Frederick, Maryland 21701																					
31. Date filed (Month, Day, Year) MAY 20 1999		32. Registrar's Signature B. Spauld																			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

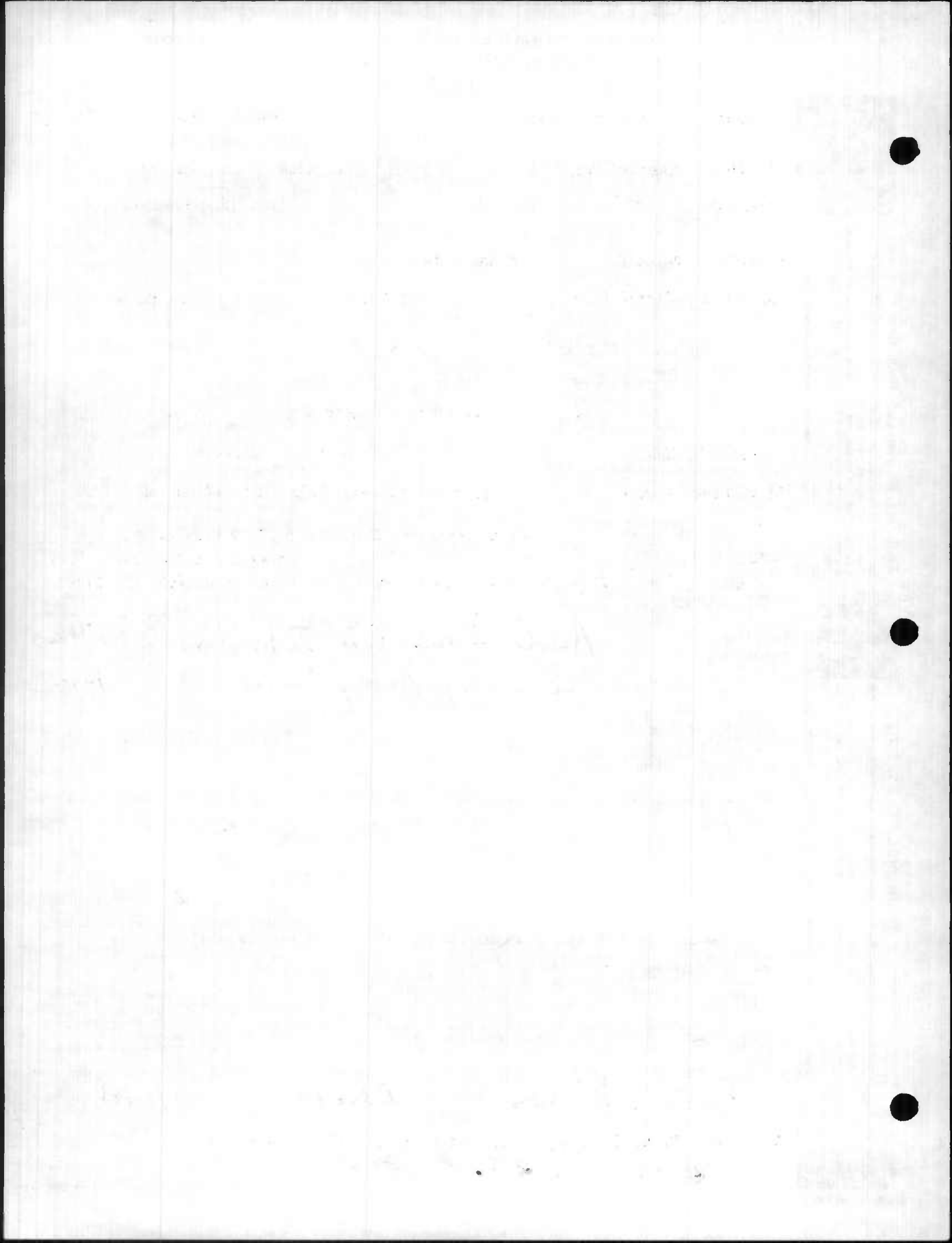
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18871

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMILY W. OLDFIELD				2. Date of Death Month Day Year May 27, 1999		3. Time of Death 5:50 A.M.	
	4a. Facility Name (If not institution, give street and number) Vindobona Nursing Home				4b. City, Town, or Location of Death Braddock Heights		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 050-07-0992		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 26, 1909	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 6705 Springhill Dr.				10f. Zip Code 21702		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales			16b. Kind of Business/Industry Real Estate	
17. Father's Name (First, Middle, Last) William S. Whelen				18. Mother's Name (First, Middle, Maiden Surname) Florence Albus				
19a. Informant's Name/Relationship (Type, Print) Susan Wallace / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6705 Springhill Dr./ Frederick, MD. 21702				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date 5-28-99		20c. Location - City or Town, State Hagerstown, Maryland
21. Signature of Funeral Service Licensae <i>Raymond Peterson</i>				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD. 21702				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. diastolic dysfunction Due to (or as a consequence of): c. coronary artery disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {								Approximate Interval Between Onset and Death years years years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recurrent transient ischemic attacks, Renal insufficiency						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Kathleen W Stern MD		29c. License number D32073		29d. Date signed (Month, Day, Year) 5/27/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen W Stern MD, 610 Ninth Ave, Brunswick, Md. 21716								
31. Date filed (Month, Day, Year) MAY 28 1999				32. Registrar's Signature <i>B. Sparks</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18872

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Archie Francis Payne, Jr.

2. Date of Death

May 30, 1999

3. Time of Death

4:38 pm

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

227-56-8097

6. Sex

M 2 ☒ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
01-07-43

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Jefferson

10c. City, Town or Location

Charles Town

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

113 N. Charles Street Apt. 3

10f. Zip Code

25414

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Contracting

17. Father's Name (First, Middle, Last)

Archie Francis Payne, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Grace Coontz

19a. Informant's Name/Relationship (Type, Print)

Doris Ann Payne

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 N. Charles Street Apt. 3 Charles Town WV 25414

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Furnace Mountain

Date

6-3-99 Furnace Mountain, VA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hall Funeral Home, Inc.

Box 896 Purcellville, VA 20134-0896

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)e. Subarachnoid Hemorrhage
Due to (or as a consequence of):b. Ruptured subcranial Aneurysm
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Swami Nathan MD

29c. License number

18414

29d. Date signed (Month, Day, Year)

5-31-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Swami NATHAN, MD 198 THOMAS JOHNSON DR #207 FREDERICK, MD 21702

31. Date filed (Month, Day, Year)

JUN 09 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202.686.0000.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

THOMASINE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

PERSON ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-10-99

Certificate of Death

Reg. No.

99 18873

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMASINE PERSON				2. Date of Death Month Day Year MAY 25, 1999		3. Time of Death 4:42 P.M.	
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 578-70-8181	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-03-53		9. Birthplace (State or Foreign Country) District of Columbia
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Montgomery		10c. City, Town or Location Adelphi			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 8901 Trapper Court			10f. Zip Code 20783		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant			16b. Kind of Business/Industry Financial		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Howard Pendergraft				18. Mother's Name (First, Middle, Maiden Surname) Agnes Victoria Dickerson Person			
	19a. Informant's Name/Relationship (Type, Print) Curtis Person - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8901 Trapper Court; Adelphi, MD 20783			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Data 6-01-99		20c. Location - City or Town, State Bladensburg, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave NW; Washington, DC 20011			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COCAINE INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) UNKNOWN		28b. Time of Injury UNKNOWN M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNKNOWN		28d. Describe how injury occurred UNKNOWN					
	28f. Location (Street and Number or Rural Route Number, City or Town, State) UNKNOWN							
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 26, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Restaneo 111 Penn Street, Baltimore, Maryland 21201							
3 AH	31. Date filed (Month, Day, Year) JUN 10 1999		32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18874

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Virginia Snyder

2. Date of Death

May 26, 1999

3. Time of Death

10:22 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

214-10-3912

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

8. Date of Birth

Dec. 1, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12 Sunny Court

10f. Zip Code

21788

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John

Fulmer

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Shank

19a. Informant's Name/Relationship (Type, Print)

David L. Lewis, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8206 Winter Snow Court, Frederick, Md. 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery, May 29, 1999

Date

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Richard E. Inhof

MO0255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home
106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

STROKE

Approximate Interval Between Onset and Death

3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

ATRIAL FIBRILLATION

UNKNOWN

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Boyd A. Dwyer MD

29c. License number

D37501

29d. Date signed (Month, Day, Year)

5/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOYD A. DWYER MD 801 TOLL HOUSE AVE BLDG H-6

FREDERICK, MD 21701

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 10875

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Catherine Betty WILSON

2. Date of Death

Month Day Year
May 26, 1999

3. Time of Death

4:22pm

4a. Facility Name (If not institution, give street and number)

1421 Taney Avenue, #605

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

220-28-2707

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 11, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1421 Taney Avenue, Apt 605

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

John Edwin KING

18. Mother's Name (First, Middle, Maiden Surname)

Annie Pearl TOMS

19a. Informant's Name/Relationship (Type, Print)

Tina Marie Osborne/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

225 West Patrick St, #6, Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Linden Hills Cemetery May 29, 1999 Frederick, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Keeney & Basford P.A. Funeral Home
MO0706

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *CARDIOMYOPATHY*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Several yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*CONGESTIVE HEART FAILURE**SEVERE MITRAL REGURGITATION*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

NA

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Abdul Majeed M.D.

29c. License number

D18063

29d. Date signed (Month, Day, Year)

May 27, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Abdul Majeed, M.D., 801 Tollhouse Avenue, C-3 Frederick, Maryland 21701

State
Registrar

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

Benita B. Spaulding

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

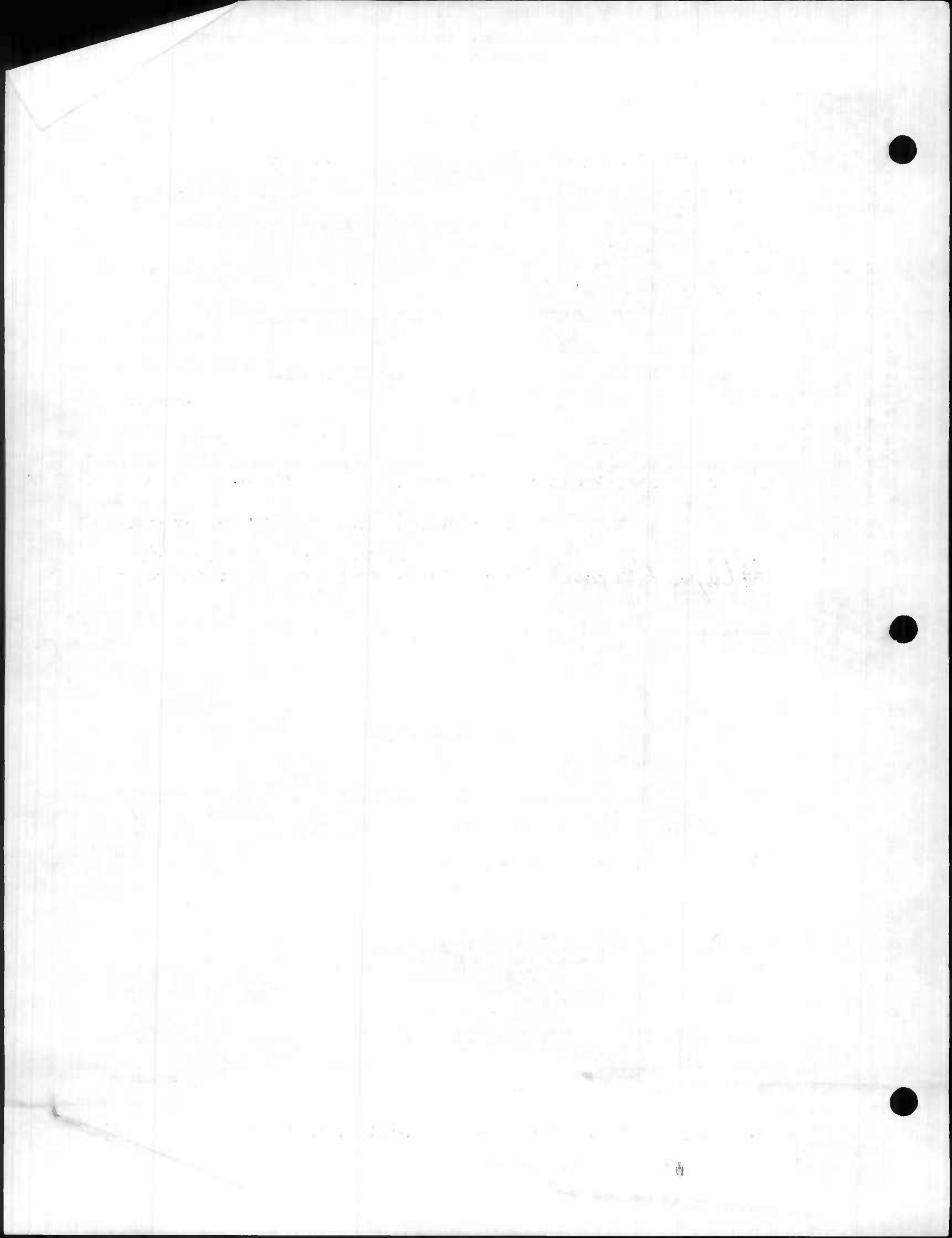
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18876

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lois Elaine Wunderlich

2. Date of Death
Month Day Year

June 1 1999

3. Time of Death

5:50P

Funeral
Director

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

218-20-3899

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

June 17, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

140 Sunset Drive

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
Caucasian15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

John William Emory

18. Mother's Name (First, Middle, Maiden Surname)

Mary Eva Webster

19a. Informant's Name/Relationship (Type, Print)

Lisa A. Taylor

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9079 Sage Court, Easton, Maryland 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Denton Cemetery

Date

6/4/99

20c. Location - City or Town, State

Denton, Maryland

21. Signature of Funeral Service Licensee

Randolph P. Moore

22. Name and Address of Facility

Moore Funeral Home, P. A.
12 South Second Street, Denton, Maryland 21629

23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *ATHRO SCLEROTIC Cardiovascular Disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ludwig J. Eglseder

29c. License number

D 31466

29d. Date signed (Month, Day, Year)

6/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ludwig J. Eglseder, M.D., 505 Dutchmen's Lane, Easton, Maryland 21601

31. Date filed (Month, Day, Year)

JUN - 4 1999

32. Registrar's Signature

*Gene B. Sparks*State
Registrar

Lois Wunderlich

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Presbyterian

100 - 1000 - 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18877

AMENDED ITEM #2 PER M.D. G772 6/14/99 AH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HILDA Marie Adams				2. Date of Death Month Day Year JUNE 8 1999		3. Time of Death 10:30 AM	
	4a. Facility Name (If not institution, give street and number) GENESIS ELDERCARE - CROMWELL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 015-32-0623	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB 28, 1903		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State Maryland		10b. County BALTIMORE		10c. City, Town or Location Lutherville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 124 Lincoln Ave				10f. Zip Code 21093		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry Private family		
17. Father's Name (First, Middle, Last) Josiah Sterrett				18. Mother's Name (First, Middle, Maiden Surname) Florence Myers				
19a. Informant's Name/Relationship (Type, Print) EUNICE BRISCOE / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 E. Coldspring Lane Baltimore, Maryland 21212				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Rest Cemetery		Date 6-15-99		20c. Location - City or Town, State Towson, Maryland		
21. Signature of Funeral Service Licensee Gray Hume				22. Name and Address of Facility CHATHAM - HARRIS P.H. 6240 REIS TERSTOWN ROAD BALTIMORE, Maryland 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic coronary artery disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death one y.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier M. Kowalcowski						
29c. License number 021022		29d. Date signed (Month, Day, Year) 6-10-99						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. KOWALCOWSKI 8115 SANDPIPER CIRCLE SAKO MD 21236								
31. Date filed (Month, Day, Year) JUN 14 1999				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

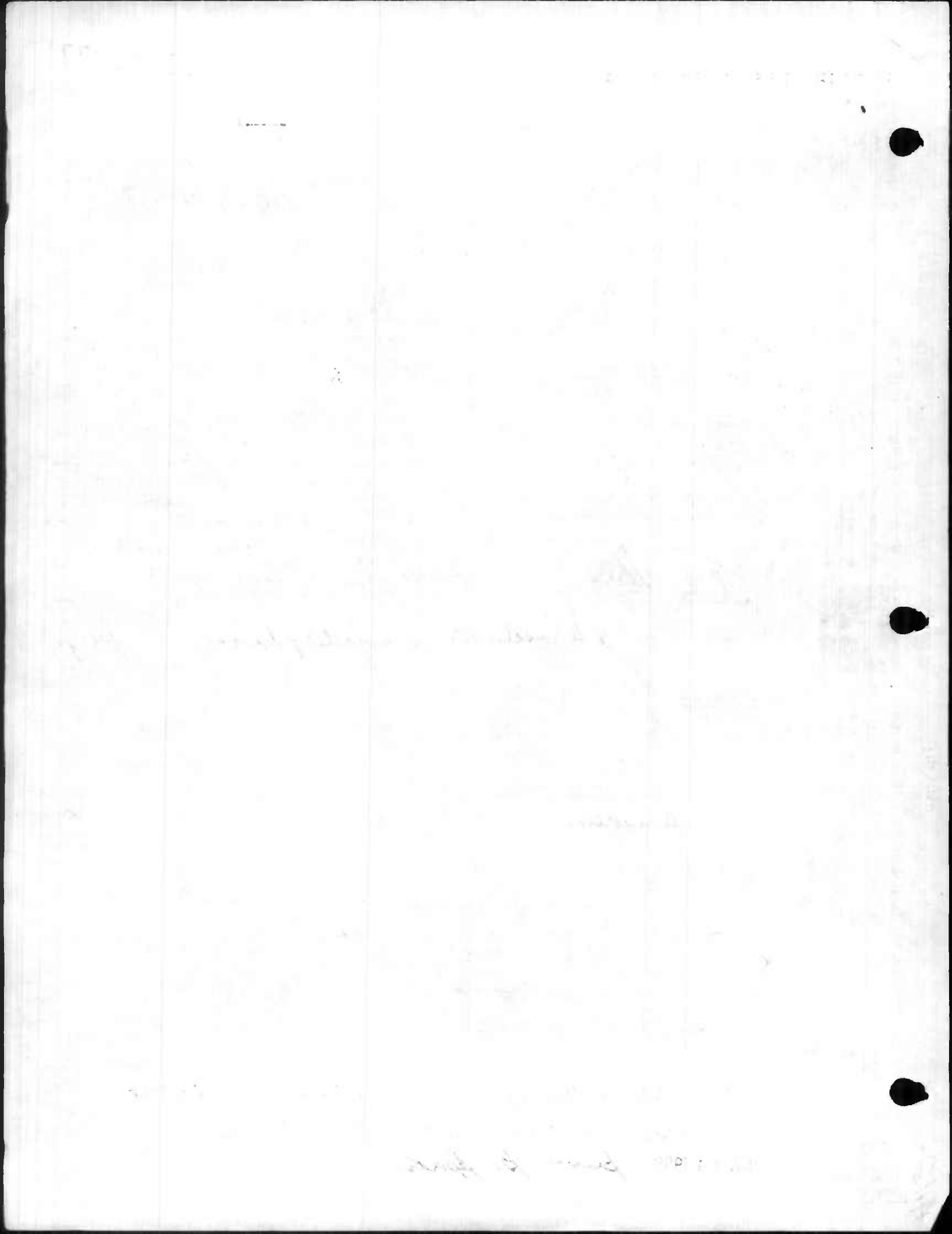
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18878

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Burnett Bryson					2. Date of Death Month Day Year June 10, 1999		3. Time of Death 8:23 P.M.																																						
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center					4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore																																						
Funeral Director	5. Social Security Number 139-03-4434		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) May 27, 1916		9. Birthplace (State or Foreign Country) California																																					
	Usual Residence of Decedent																																													
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Middle River				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																						
10e. Street and Number 11 Left Wing Drive					10f. Zip Code 21220		10g. Citizen of What Country? U.S.A.																																							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																																						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics Technician			16b. Kind of Business/Industry U.S. Government																																						
17. Father's Name (First, Middle, Last) George B. Bryson					18. Mother's Name (First, Middle, Maiden Surname) Myrtle Leibig																																									
19a. Informant's Name/Relationship (Type, Print) Eleanor L. Bryson (wife)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Left Wing Drive, Baltimore, Maryland 21220																																									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Darlington Meth Ch. Cem.			20c. Location - City or Town, State 6/14/99 Harford Co. Maryland																																								
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221																																									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																														
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) a. <u>CARDIO PULmonary ARREST</u> Due to (or as a consequence of): b. <u>VAScular Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td colspan="9"></td> </tr> <tr><td colspan="9"></td></tr> <tr><td colspan="9"></td></tr> <tr><td colspan="9"></td></tr> </table>										Immediate Cause (Final disease or condition resulting in death) a. <u>CARDIO PULmonary ARREST</u> Due to (or as a consequence of): b. <u>VAScular Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																																				
Immediate Cause (Final disease or condition resulting in death) a. <u>CARDIO PULmonary ARREST</u> Due to (or as a consequence of): b. <u>VAScular Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																																														
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																																														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																														
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Seizure Disorder, Stroke, Hypertension</u>																																														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																																					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)																																									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																														
29b. Signature and title of certifier 					29c. License number D41464		29d. Date signed (Month, Day, Year) 6/11/99																																							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Leont, M.D. 3508 Bank St Balto, Md 21224																																														
31. Date filed (Month, Day, Year) JUN 14 1999					32. Registrar's Signature 																																									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18879

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth J. Beegle				2. Date of Death Month Day Year June 14, 1999				3. Time of Death 8:45 a.m.		
	4a. Facility Name (If not institution, give street and number) 3-B Valley Arbor Court				4b. City, Town, or Location of Death Essex				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 723-14-7753		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	6. Date of Birth (Month, Day, Year) April 13, 1928		9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 3-B Valley Arbor Court				10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WYII If Yes, Give Year or Dates: to 1/48		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Man			16b. Kind of Business/Industry Vending Company			
	17. Father's Name (First, Middle, Last) Franklin T. Beegle				18. Mother's Name (First, Middle, Maiden Surname) Mabel R. Robinson						
	19a. Informant's Name/Relationship (Type, Print) Norma Jean Baker (niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3-B Valley Arbor Court, Baltimore, Maryland 21221						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Veterans cemetery		Date 6/16/99		20c. Location - City or Town, State Garrison Forest, Md.				
	21. Signature of Funeral Service Licensee John W. Burkowski				22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Easton Avenue, Essex, Maryland 21221						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypoxemia Due to (or as a consequence of): b. Metastatic Lung Cancer Due to (or as a consequence of): c. Chronic Obstructive Lung Disease Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1 hour 2 months years						
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28b. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier [Signature]				29c. License number 253462		29d. Date signed (Month, Day, Year) 6/14/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude Munozes MD 2112 Belair Rd. Suite 9 Fallston, MD											
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature [Signature] 21047									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18880

AMENDED ITEM #2 PER MD G772 6/14/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Franklin Burris

2. Date of Death

Month
JUNEDay
7Year
1999

3. Time of Death

9:00 PM

4a. Facility Name (If not institution, give street and number)

2512 TERRA FIRMA ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-05-1648

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year

Mar. 31, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2512 TERRA FIRMA ROAD

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TRACK MAN

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

ED

18. Mother's Name (First, Middle, Maiden Surname)

REVA HINTER

19a. Informant's Name/Relationship (Type, Print)

REVA STEPHENS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3003 WYCLIFF AVE BALTIMORE, Maryland 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison First Veterans Cem

Date

6/15/99

20c. Location - City or Town, State

Owings Mills, Md

21. Signature of Funeral Service Licensee

Derry Harris

22. Name and Address of Facility

CHATMAN - HARRIS F.H.
5240 REISTERSTOWN ROAD
BALTIMORE, Maryland 2121123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Urethral Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christian D. Bounds MD

29c. License number

P10207

29d. Date signed (Month, Day, Year)

06-09-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christian D. Bounds MD 16 S. Eutan St Baltimore MD 21201

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

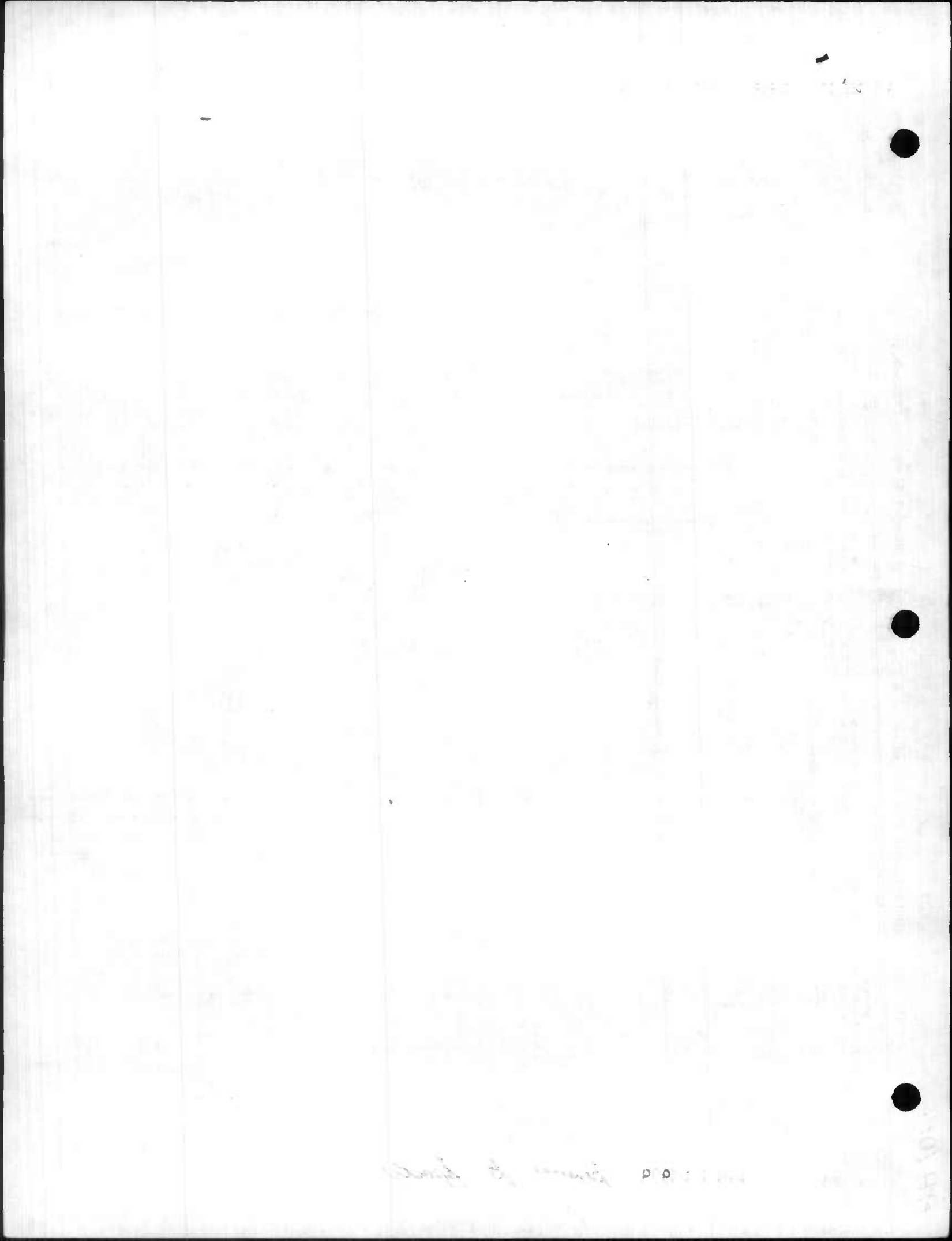
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Copy of [illegible]

pp. 1-2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18881

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NATALIE BRENNER				2. Date of Death Month Day Year JUNE 8 1999		3. Time of Death 12:05PM	
	4a. Facility Name (If not institution, give street and number) 6928 MARSUE DRIVE #1C				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 212-01-7420	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAR.13,1918		9. Birthplace (State or Foreign Country) MASS.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County BALTIMORE	10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 6928 MARSUE DRIVE #1C			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) ALBERT SEIDEL				18. Mother's Name (First, Middle, Maiden Surname) IDA SEIDEL			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) NATHAN BRENNER / HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6928 MARSUE DRIVE #1C - BALTIMORE, MD 21215			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ADATH YESHURUN CEMETERY		Date 6/10/99	20c. Location - City or Town, State BALTIMORE, MD		
	21. Signature of Funeral Service Licensee <i>Scott M. Cottle</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Cardiorespiratory failure</i> Due to (or as a consequence of): b. <i>Myocardial infarction</i> Due to (or as a consequence of): c. <i>Metastatic Cancer wide spread</i> Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Metastatic spinal cord with paraplegia</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>David J. Penn MD</i>		29c. License number D24928		29d. Date signed (Month, Day, Year) 6/9/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David J. Penn 3635 Old Ct Rd Suite 610 Pikesville MD 21208.								
State Registrar	31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18882

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bessie W. Bolles					2. Date of Death Month Day Year June 8 1999		3. Time of Death 10:04 a.m.		
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital					4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 217-34-4374		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 18, 1938		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Jessup			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2031 Citrus Avenue				10f. Zip Code 20794		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Wilbur Carroll Woerner, Jr.					18. Mother's Name (First, Middle, Maiden Surname) Louise M. Gore				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Scott Bolles/ Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2031 Citrus Avenue Jessup, Maryland 20794					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park			Date 6/11/99		20c. Location - City or Town, State Elkridge, Maryland		
	21. Signature of Funeral Service Licensee <i>Stan F. Lubke</i>				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. adult respiratory distress syndrome Due to (or as a consequence of): 3 days b. ischemic bowel with complications Due to (or as a consequence of): 6 days c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. history of left pneumonectomy on June 4, 1998						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>L. Jarrott Moore, MD</i>		29c. License number P12583		29d. Date signed (Month, Day, Year) June 12, 1999			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) L. Jarrott Moore, MD 201 East University Parkway Baltimore, MD 21218									
State Registrar	31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature <i>B. Sparks</i>							

Bolles, Bessie W.
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

MD STATE

A148

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dear Mr. [illegible]

[illegible]

[illegible]

[illegible]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #g, 13, 18 PER F.H. G772 6-14-99 WR.

Certificate of Death

Reg. No. 99 18883

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carmen Campbell				2. Date of Death Month Day Year June 12, 1999				3. Time of Death 3:55pm	
	4a. Facility Name (If not institution, give street and number) Care Matrix Nursing Home				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 382-03-5704		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Feb. 26, 1910		9. Birthplace (State or Foreign Country) Jamaica		10a. State MD		10b. County Montgomery		10c. City, Town or Location Takoma Park	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 109 Sheridan Avenue		10f. Zip Code 20912		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Jamaican		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician		16b. Kind of Business/Industry Beauty Parlor		17. Father's Name (First, Middle, Last) Jonathon E. Campbell		18. Mother's Name (First, Middle, Maiden Surname) Georgiana Hert		19a. Informant's Name/Relationship (Type, Print) Belle Ziegler / Sister		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Sheridan Avenue, Takoma Park MD 20912		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cem. June 15, 1999		20c. Location - City or Town, State Baltimore MD		21. Signature of Funeral Service Licensee Victor P. Doda		
22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Atherosclerotic coronary / vascular disease Due to (or as a consequence of):		Approximate interval between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier James P. Asher		29c. License number D34032		29d. Date signed (Month, Day, Year) 6-13-99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeanne P. Asher, MD 3720 Farragut Ave, Kensington MD 20845		
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature James P. Asher		State Registrar		743		DHMH 16 Rev 6/95		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18884

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Don Su Chong				2. Date of Death Month Day Year JUNE 10, 1999		3. Time of Death 0237 AM	
	4e. Facility Name (If not institution, give street and number) SAINT JOSEPH HOSPITAL				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 531-27-3376		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 24 1949	
	9. Birthplace (State or Foreign Country) Korea		10a. State MD		10b. County Baltimore		10c. City, Town or Location Cockeysville	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1017 Misty Lynn Circle K		10f. Zip Code 21030		
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: Korean		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manufacturing		16b. Kind of Business/Industry Musical Instruments		
17. Father's Name (First, Middle, Last) Sin Wha Chong				18. Mother's Name (First, Middle, Maiden Surname) Gea Dan Choi				
19e. Informant's Name/Relationship (Type, Print) Mrs. Chong Suk Chong/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1017 Misty Lynn Circle K Cockeysville, MD. 21030				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mountain View Cemetery		Date 6/14/99		20c. Location - City or Town, State Aupurn, Washington		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number O.C.M..E.		29d. Date signed (Month, Day, Year) JUNE 10, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature 						


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18885

Amended item#5,19a perFH G772 6/14/99 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MORTON COSMAN				2. Date of Death Month JUNE Day 9 Year 1999		3. Time of Death 7:20 AM	
	4a. Facility Name (If not institution, give street and number) CHERRYWOOD NURSING HOME				4b. City, Town, or Location of Death REISTERSTOWN		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 214 214-14-0528		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) FEB 1, 1922	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 6 POMONA NORTH, APT. 1		10f. Zip Code 21208		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII ARMY		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSTALLER		16b. Kind of Business/Industry DRAPERY			
	17. Father's Name (First, Middle, Last) NATHAN COSMAN		18. Mother's Name (First, Middle, Maiden Surname) SARA SACHS		19a. Informant's Name/Relationship (Type, Print) OWEN COSMAN (WIFE) Gwendolyn Cosman			
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 POMONA NORTH, APT. 1 BALTO., MD 21208		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) OHEB SHALOML MEM. PARK		20c. Location - City or Town, State 6/11/99 REISTERSTOWN, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Parkinson's Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration pneumonia (probable)							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29d. Date signed (Month, Day, Year) 6/9/99
	29b. Signature and title of certifier 		29c. License number 027123					
State Registrar	30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) Julie Morrow 770 Main St Reisterstown, MD 21117							32. Registrar's Signature 
	31. Date filed (Month, Day, Year) JUN 14 1999							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18886

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Carter				2. Date of Death Month Day Year June 12th 1999		3. Time of Death 4:07am	
	4a. Facility Name (If not institution, give street and number) Bon Secour Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death NIA	
Funeral Director	5. Social Security Number 228-05-0507		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 9, 1918	9. Birthplace (State or Foreign Country) S. Carolina
	Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 2574 W. Fairmount Ave.				10f. Zip Code 21223		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Can	
17. Father's Name (First, Middle, Last) William Brown					18. Mother's Name (First, Middle, Maiden Surname) Emma Lewis			
19a. Informant's Name/Relationship (Type, Print) Hester Johnson - daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1610 Lemmon St. Balto, MD. 21223			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date 6-19-99	20c. Location - City or Town, State Lansdowne, MD.		
21. Signature of Funeral Service Licensee James H. March					22. Name and Address of Facility Sara E. March Funeral Home P.A. 5701 Fredrickson Pass, Balto, MD. 21229			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Incarcerated Ventral Hernia Due to (or as a consequence of): b. Bilateral Pneumonia Due to (or as a consequence of): c. Acute Renal Failure Due to (or as a consequence of): d. Gastro intestinal Bleed.								Approximate Interval Between Onset and Death 10 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Steven Elder MD House officer					29c. License number D38993		29d. Date signed (Month, Day, Year) June 12th 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Elder 2600 Liberty Hgts Baltimore MD 21215.								
31. Date filed (Month, Day, Year) JUN 14 1999				32. Registrar's Signature Anna B. Sparks				

Baltimore, Maryland 21215-0020

permit it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18887

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Inge Day

2. Date of Death

Month
JuneDay
9Year
1999

3. Time of Death

6:05 pm

Funeral
Director

4e. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-22-1980

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

19

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
04-17-20

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 E. PRESTON STREET

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

JOHN COOPER

18. Mother's Name (First, Middle, Maiden Surname)

BELLE COLLINS

19a. Informant's Name/Relationship (Type, Print)

GARY WILLIAMS FRIEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3320 REDDICOAT CT., BALTO. MD. 21163

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK

Date

6-14-99 RANDALSTOWN, MD

21. Signature of Funeral Service Licenses

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute congestive heart failure

Approximate Interval Between Onset and Death

2 hrs

Due to (or as a consequence of):

b. Probable myocardial infarction

4 hrs

Due to (or as a consequence of):

c. Ischemic cardiomyopathy

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.

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State of Maryland / Department of Health and Mental Hygiene

99 18888

ITEM: #26 PER A.B. G762 6-14-99 WR.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ellen Dean

2. Date of Death

Month

Day

Year

3. Time of Death

3:45PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Long Green Center - Genesis Eldercare

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

216-01-7945

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 21, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

115 E. Melrose Avenue

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dry Cleaner

16b. Kind of Business/Industry

Dry Cleaning

17. Father's Name (First, Middle, Last)

Charles William Seymour

18. Mother's Name (First, Middle, Maiden Surname)

Sophia Elizabeth Winter

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street

Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Asystole

minutes

b.

Due to (or as a consequence of):

Hyperkalemia

Days

c.

Due to (or as a consequence of):

Acute renal Failure

unknown

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease

ASHD with old infarctions

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Medical Attending

29c. License number

D17118

29d. Date signed (Month, Day, Year)

4/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Schwartz M.D.

115 E. Melrose Ave

21212

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

Geneva B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18889

AMENDED ITEM #11 PER INFORM. G773 7/1/99 AH

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Robert Carr Doyle

2. Date of Death

May 21, 1999

3. Time of Death

12:40AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

578-18-3161

6. Sex

125 M 20 F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 24, 1921

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

28 West Kirke St.

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Television Consultant

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Henry Grattan Doyle

18. Mother's Name (First, Middle, Maiden Surname)

Marion Sharkey

19a. Informant's Name/Relationship (Type, Print)

Nancy D. Palmer-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4150 Linnean Ave. NW, Washington, DC 20008

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

National Crematory

Date

6/1/1999 Falls Church, VA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016

22. Name and Address of Facility

Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Aspiration Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Odontoid fracture - repaired April 1999

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home

5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

David A. Holden MD

29c. License number

D 47791

29d. Date signed (Month, Day, Year)

May 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David A. Holden 809 Veirs Mill Rd, Rockville, Maryland 20851

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

Suzanne B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18890

Amended Item#4c perPhyG772 6/14/99 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IDA DILLON				2. Date of Death Month JUNE Day 9 Year 1999		3. Time of Death 1500		
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore RANDALLSTOWN		
Funeral Director	5. Social Security Number 215-34-2034		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02-28-1914	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Pikesville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 2 Ivanhoe Place				10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Joseph M. Ward				18. Mother's Name (First, Middle, Maiden Surname) Blanch Hunt					
19a. Informant's Name/Relationship (Type, Print) Harry M. Dillon (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1151 Severnview Drive Crownsville, MD 21032					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. Location - City or Town, State 6-12-99 Sykesville, Maryland			
21. Signature of Funeral Service Licensee  J. Wayne Osterling				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of): b. Cardio-Pulmonary failure Due to (or as a consequence of): c. Septicemia Due to (or as a consequence of): d. Pneumonia, Cellulitis Rt. leg								Approximate Interval Between Onset and Death 5 yr 2 yr 3 wks 3 wks	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gout, osteoarthritis								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier  M. Attending Physician	
29c. License number D15938				29d. Date signed (Month, Day, Year) 6/4/99				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MALINEE YUXTONGTING, M 5400 Old Court Rd Randallstown MD 21133	
31. Date filed (Month, Day, Year) JUN 14 1999				32. Registrar's Signature  P. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

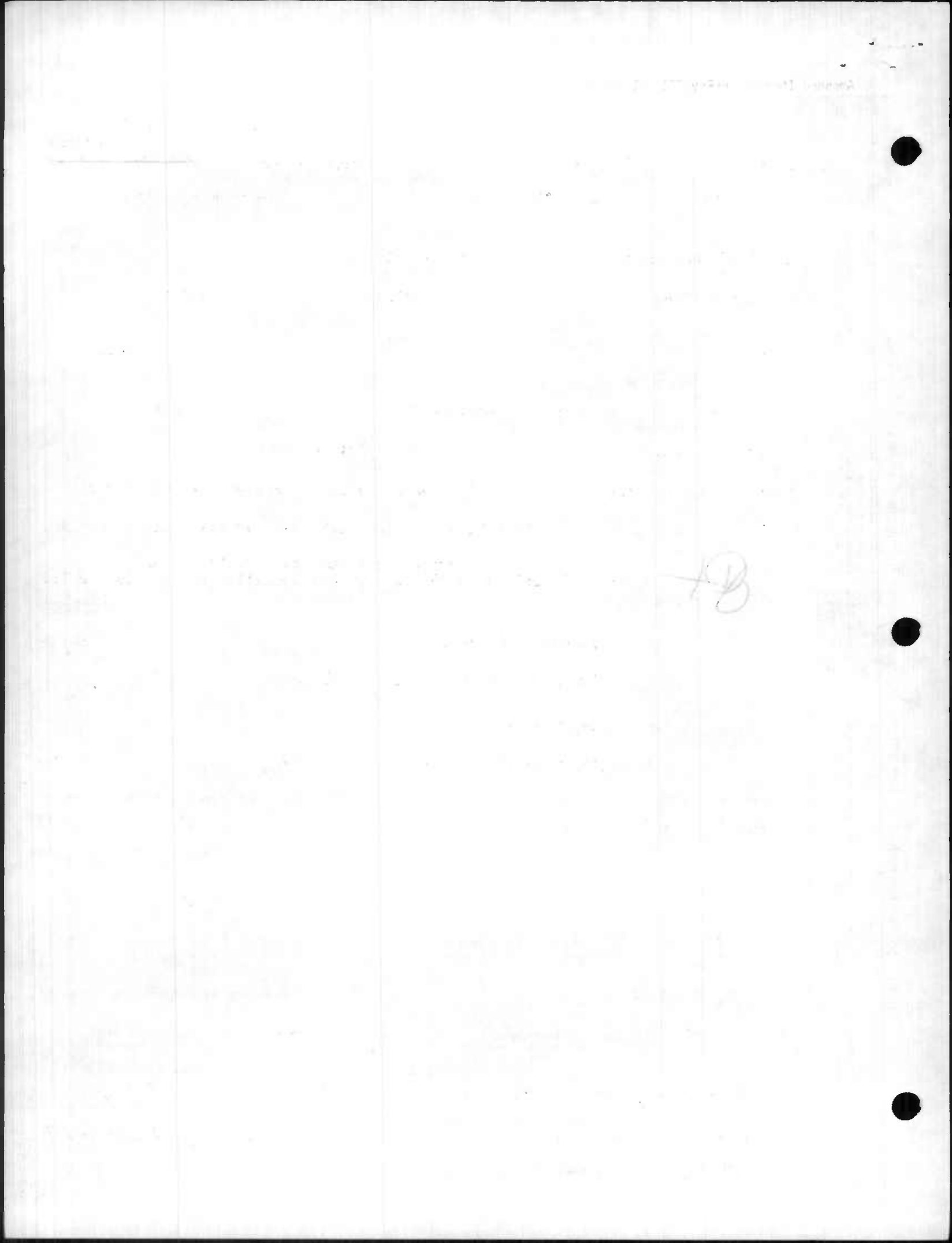
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in full in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



99-3273-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

KEVIN

State of Maryland / Department of Health and Mental Hygiene

DAIN ITEMS: #23 PART I, 27 PER MEO G772 6-28-99 WR.

Certificate of Death

Reg. No. 99 18891

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KEVIN L. DAIN						2. Date of Death Month Day Year JUNE 9, 1999		3. Time of Death 5:12P.M.	
	4a. Facility Name (If not institution, give street and number) 1609 HUTZLER LANE						4b. City, Town, or Location of Death PIKESVILLE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 318-44-7663		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 4, 1960		9. Birthplace (State or Foreign Country) ILL.	
	Usual Residence of Decedent									
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location PIKESVILLE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1609 HUTZLER LANE APT. 2122						10f. Zip Code 21208		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (14 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REGISTERED NURSE				16b. Kind of Business/Industry HEALTH CARE		
17. Father's Name (First, Middle, Last) ARLYN DAIN						18. Mother's Name (First, Middle, Maiden Surname) EVELYN M. DAILEY				
19a. Informant's Name/Relationship (Type, Print) EVELYN DAIN (MOTHER)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 W. MAPLE ST. HOPESTON ILL. 60942				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) PARK CEMETERY			20c. Location - City or Town, State 6/14/99 OGDENSBURG, Wisc.				
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility DELLA NOCE + SONS FUNERAL HOME 322 S. HIGH ST. BALTO. MD. 21202				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEIZURE DISORDER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 10, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, Jr. 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JUN 14 1999			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

18892

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Lee DuDonis				2. Date of Death Month Day Year June 10 1999		3. Age (In yrs. last birthday) 70	4. City, Town, or Location of Death BALTIMORE	5. County of Death N/A
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSP.				6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Social Security Number 220-22-1308	8. Date of Birth (Month, Day, Year) Nov. 22, 1928	9. Birthplace (State or Foreign Country) Maryland
Funeral Director	10a. State Maryland				10b. County Baltimore		10c. City, Town or Location Lansdowne		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 2360 Research Avenue				10f. Zip Code 21227		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean War		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry Crown Cork & Seal			
17. Father's Name (First, Middle, Last) John DuDonis				18. Mother's Name (First, Middle, Maiden Surname) Beatrice Kroedel					
19a. Informant's Name/Relationship (Type, Print) LaVelle DuDonis (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2360 Research Ave. Lansdowne, Maryland 21227					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		20c. Date 6/14/99		20d. Location - City or Town, State Elkridge, Maryland	
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION 2 days Due to (or as a consequence of): b. LUNG CANCER 1 month Due to (or as a consequence of): c. PNEUMONIA 1 week Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Horea Rus M.D.				29c. License number P12703		29d. Date signed (Month, Day, Year) June 10, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOREA RUS STAGNES 900 CATON AVE BALTIMORE									
31. Date filed (Month, Day, Year) JUN 14 1999				32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18893

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAUL FLAX				2. Date of Death Month Day Year JUNE 3, 1999		3. Time of Death 1016 AM	
	4a. Facility Name (If not institution, give street and number) 1027 CATHEDRAL STREET APARTMENT 5C				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-16-5873		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) OCT 16, 1921	
	9. Birthplace (State or Foreign Country) NEW YORK		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1027 CATHEDRAL ST., APT. 5-C		10f. Zip Code 21201		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DISPATCHER		16b. Kind of Business/Industry CAB COMPANY		
17. Father's Name (First, Middle, Last) ISAAC J FLAX				18. Mother's Name (First, Middle, Maiden Summa) ESTHER GOLDSTEIN				
19a. Informant's Name/Relationship (Type, Print) MAURICE OFFIT, ATTY.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 PARK CENTER CT., SUITE 200 OWINGS MILLS, MD 21117				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERANS		Date 6/10/99		20c. Location - City or Town, State OWINGS MILLS, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <u>in question</u> 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 4, 1999		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) THEODOR M. KING 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18894

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN A. FREYMAN

2. Date of Death

Month Day Year
JUNE 11 1999

3. Time of Death

8:45 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

214-54-9004

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 11, 1949

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

712 DOROL CT.

10f. Zip Code

21144

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: '66-'69

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
WHITE15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SP4, U.S. ARMY

16b. Kind of Business/Industry

MILITARY

17. Father's Name (First, Middle, Last)

DAVID E. FREYMAN, SR.

18. Mother's Name (First, Middle, Maiden Surname)

HELEN DRURY

19a. Informant's Name/Relationship (Type, Print)

DEBORAH A. FREYMAN / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

712 DOROL CT., SEVERN, MARYLAND 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CROWNSVILLE MD. VET. CEM.

Date

JUNE 14

20c. Location - City or Town, State

CROWNSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

KIRKLEY-RUDDICK FUNERAL HOME, P.A.

421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. UROSEPSIS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MYOCARDIAL INFARCTION.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

MD.

29c. License number

D43977

29d. Date signed (Month, Day, Year)

June 11 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cheryl Dratmire, 301 Hospital Drive, Glen Burnie, MD. 21061

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

[Signature]State
RegistrarFREYMAN, JOHN A.
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #27, 28D PER MEO G773 9-2-99 WR.

ITEMS: #23 PART I, 27, 28A-F PER MEO G773 7-1-99 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18895

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JORDAN B. GARRIS

2. Date of Death

Month Day Year
JUNE 08, 1999

3. Time of Death

7:59 PM.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL PEDIATRIC

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

Unk

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

3

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10-06-95

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6 N. ELLWOOD AVENUE

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (14 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

CLIFTON GARRIS

18. Mother's Name (First, Middle, Maiden Surname)

MELISSA HALLIDAY

19a. Informant's Name/Relationship (Type, Print)

MELISSA HALLIDAY / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 N ELLWOOD AVE., BALTO. MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOW BROGE CEMETERY 6-12-99 ELKBRIDGE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GUNSHOT WOUND HEAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☒ Could not be determined

28a. Date of Injury

(Month, Day, Year)
6-6-99

28b. Time of Injury

5:15

P

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 N. ELLWOOD AVE., BALTIMORE, MD

29a. Certifier (Check only)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Vaughn C. Greene

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JUNE 09, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JASON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

100-100000-1 100-100000-1 100-100000-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18896

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George H. Groth				2. Date of Death Month JUNE Day 09 Year 1999		3. Time of Death 10:55PM	
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 214-12-0563		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) May 19, 1914	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore Maryland	
To Be Completed by Funeral Director	10d. Inside City Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				10e. Street and Number 5 East Lake Avenue		10f. Zip Code 21212	
	10g. Citizen of What Country? United States				11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Army	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Checker		16b. Kind of Business/Industry Waterfront	
	17. Father's Name (First, Middle, Last) Henry Groth				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Cloman			
	19a. Informant's Name/Relationship (Type, Print) Lois E. Groth / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 East Lake Avenue, Baltimore Maryland 21212			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State June 12, 1999 Baltimore Maryland	
	21. Signature of Funeral Service Licensee Victor P. Doda, Jr.				22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore Maryland 21230			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebrovascular Accident				Approximate Interval Between Onset and Death 2 weeks			
	Immediate Cause (Final disease or condition resulting in death) Artrial Fibrillation				Due to (or as a consequence of): 2 years			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Liver GI bleed				Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined				28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury 1 Yes 2 No		
28c. Describe how injury occurred				28d. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Attending MD				
29c. License number 037016				29d. Date signed (Month, Day, Year) June 10, 1999				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kenneth M. Green MD 6701 N. Charles St, Suite 4105 Baltimore, MD 21204				31. Date filed (Month, Day, Year) JUN 14 1999				
32. Registrar's Signature Sparks				33. State Registrar State Registrar				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18897

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Targrave M. Gregg

2. Date of Death

June 12 1999

3. Time of Death

9:05 am

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

258-03-2301

6. Sex

M 2 F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 29 1918

9. Birthplace (State or Foreign Country)

S. Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 X 2 No

10e. Street and Number

827 N. Arlington Ave

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 X Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 YEARS

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

ALLEGHENY HARDWARE
(PLUMBING SUPPLY CO.)

17. Father's Name (First, Middle, Last)

ALVIN L. GREGG

18. Mother's Name (First, Middle, Maiden Surname)

HARRIE DAVIS

19a. Informant's Name/Relationship (Type, Print)

LENA GREGG / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4916 BOWLAND AVE BALTIMORE, MARYLAND 21206

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BARRISON Forest Veterans Ctr

Date

6-17-99

20c. Location - City or Town, State

MILLS, MD

21. Signature of Funeral Service Licensee

Quay Harris

22. Name and Address of Facility

CHAULMAN - HARRIS & N.
5340 REISTERSDALE ROAD
BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?

1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 X No

25. Was case referred to medical examiner?

1 Yes 2 X No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Frances E. Williams, MD

29c. License number

P10441

29d. Date signed (Month, Day, Year)

June 12, 1999

30. Name and address of person who completed cause of death (Item 25e) (Type, Print)

Frances E. Williams, MD

Sinai Hospital 2401 W. Belvedere Ave.
Baltimore, MD 21215

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-16-99 WR. **Certificate of Death**

Reg. No. **99 18898**

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Angelo Ghee, SR.		2. Date of Death Month JUNE Day 7 Year 1999		3. Time of Death 0910 AM	
4a. Facility Name (If not institution, give street and number) 1044 BRENTWOOD AVENUE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
5. Social Security Number 214-78-5363		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.	
8. Date of Birth (Month, Day, Year) 11-23-59		9. Birthplace (State or Foreign Country) MD			
Usual Residence of Decedent		10a. State MD		10b. County NA	
10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1044 Brentwood Avenue		10f. Zip Code 21202		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance	
16b. Kind of Business/Industry Colonnade		17. Father's Name (First, Middle, Last) James C. Ghee		18. Mother's Name (First, Middle, Maiden Surname) Thelma A. Keeton	
19a. Informant's Name/Relationship (Type, Print) Angelo Ghee, Jr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 5610 Denwood Avenue Baltimore, Maryland			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery		20c. Location - City or Town, State 06-14-99 Baltimore, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue			
23a. Part I: Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. NARCOTIC AND ETHANOL INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found: 6-7-99		28b. Time of Injury Found: 8:25	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1044 BRENTWOOD AVE.			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 8, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201					
31. Date and Time JUN 14 1999		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18899

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Sidney Greenfeld

2. Date of Death

June 7, 1999

3. Time of Death

0415

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

212-24-9260

6. Sex

XXM 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 25, 1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2710 JEREMY COURT #C

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

OWNER

16b. Kind of Business/Industry

LIQUOR STORE

17. Father's Name (First, Middle, Last)

SOL

GREENFELD

18. Mother's Name (First, Middle, Maiden Surname)

PAULINE

ZINS

19a. Informant's Name/Relationship (Type, Print)

BERTHA GREENFELD / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2710 JEREMY COURT #C - BALTIMORE, MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BETH JACOB CEMETERY

Date

6/9/99

20c. Location - City or Town, State

FINKSBURG, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 2120823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Massive Pulmonary Emboli

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

> 1 wk

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Bilateral Deep Venous Thrombosis

Due to (or as a consequence of):

> 2 wk

c. Metastatic Colorectal Carcinoma

Due to (or as a consequence of):

> 2 mo

d. Lymphoma

> 2 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Right Pleural Effusion

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

P12307

29d. Date signed (Month, Day, Year)

June 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LK Bonasera, MD Sinai Hospital

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

[Signature]

State
Registrar

Sidney Greenfeld

Baltimore, Maryland 21215-0020

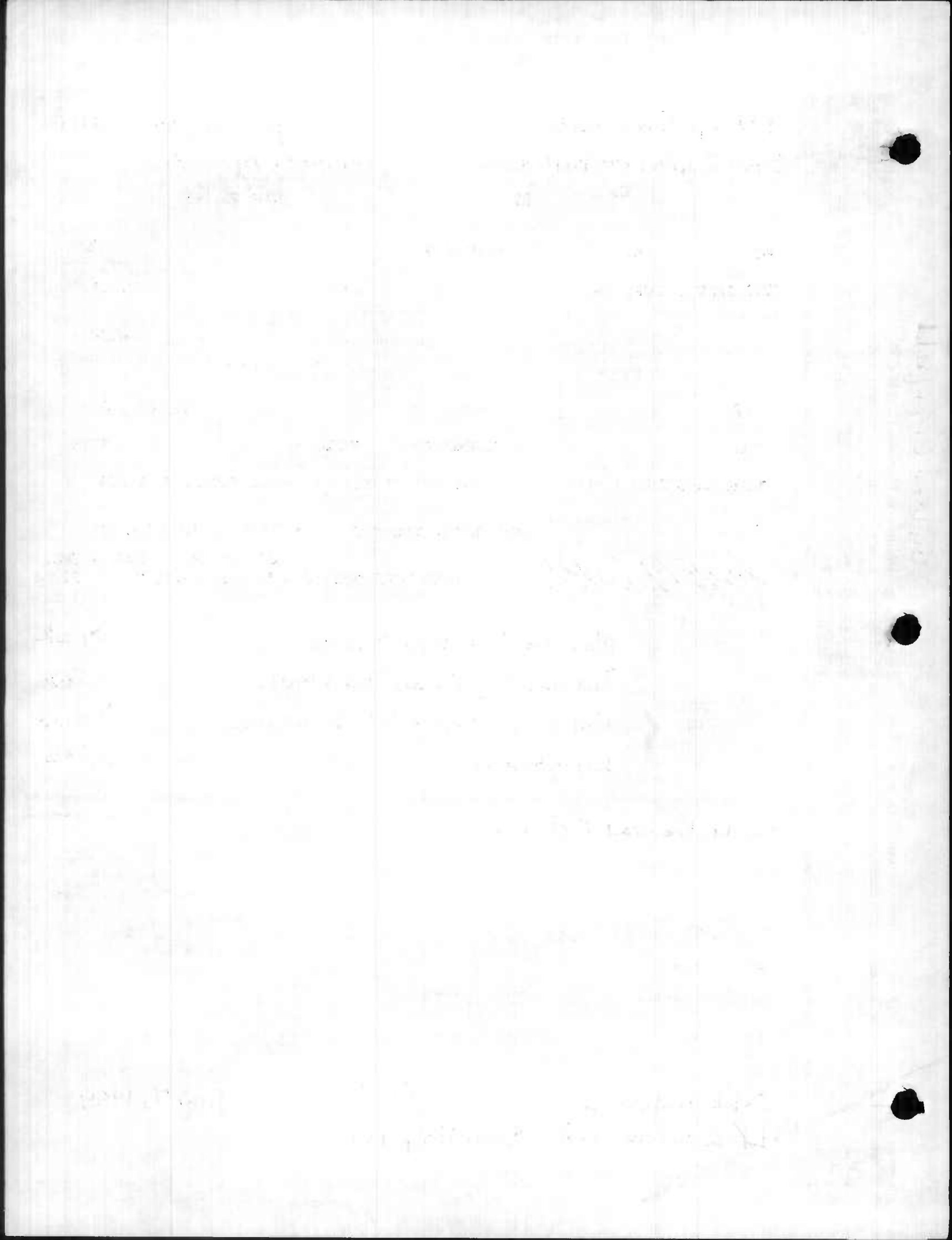
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18900

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) <i>George Griffin</i>		2. Date of Death Month <i>4</i> Day <i>21</i> Year <i>99</i>		3. Time of Death <i>1150PM</i>
4a. Facility Name (If not institution, give street and number) <i>IRVING KNOLL CARE CTR.</i>		4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>BALTIMORE</i>
5. Social Security Number <i>43662 7449</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>57</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <i>2-9-42</i>		9. Birthplace (State or Foreign Country) <i>LA</i>		
Usual Residence of Decedent				
10a. State <i>MD</i>	10b. County <i>BALTO</i>	10c. City, Town or Location <i>BALTO</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <i>22 ATHOL ST BALTO, MD</i>		10f. Zip Code <i>21219</i>		10g. Citizen of What Country?
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>US ARMY</i>		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <i>GEORGE GRIMM JR</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>DELPHINE GUNNORE</i>		
19a. Informant's Name/Relationship (Type, Print) <i>MAURE GRIMM - WIFE</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3040 ALPINE ST - KILGORE TX</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>ST JOSEPH BAPTIST CEM</i>		20c. Location - City or Town, State <i>5.1.99 EOLA, LA</i>
21. Signature of Funeral Service Licensee <i>Larry Smith</i>		22. Name and Address of Facility <i>BEARDS FUNERAL 5526 EOLA ST KILGORE TX</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. <i>Coronary Artery disease</i> Due to (or as a consequence of): c. <i>Pneumonia</i> Due to (or as a consequence of): d.				
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <i>Larry Smith</i>		29c. License number <i>D47405</i>		29d. Date signed (Month, Day, Year) <i>4/23/99</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>LIAQAT ALI 821 N-Cutw street Baltimore MD 21201</i>				
31. Date filed (Month, Day, Year) <i>JUN 11 1999</i>		32. Registrar's Signature <i>P. Sparks</i>		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18901

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Lee Hamill

2. Date of Death

Month Day Year
June 11 1999

3. Time of Death

11:46 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE

4b. City, Town, or Location of Death

4c. County of Death

BALTIMORE

5. Social Security Number

213-26-9012

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 14, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14 Ridgemoor Road

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Tarbart

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Hunt

19a. Informant's Name/Relationship (Type, Print)

David D. Hamill (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Ridgemoor Road, Baltimore, Maryland 21221

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

6/15/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

John W. Buckowski

22. Name and Address of Facility

Bruzdzinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221+

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

b. CARDIAC ARREST

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

3 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES, TYPE 2

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sylvester S. Hamilton, MD

29c. License number

186486

29d. Date signed (Month, Day, Year)

6/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sylvester S. Hamilton, MD FRANKLIN SQUARE HOSPITAL CENTER 21237

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

B. Sparks

State
Registrar

HAMILL, BETTY LEE

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results obtained. It is a general overview of the work done and the results obtained.

2. The second part of the report deals with the specific work done during the year. It is a detailed account of the work done and the results obtained. It is a detailed account of the work done and the results obtained.

3. The third part of the report deals with the conclusions drawn from the work done during the year. It is a summary of the conclusions drawn from the work done and the results obtained. It is a summary of the conclusions drawn from the work done and the results obtained.

4. The fourth part of the report deals with the recommendations made for the future work. It is a summary of the recommendations made for the future work. It is a summary of the recommendations made for the future work.

5. The fifth part of the report deals with the bibliography. It is a list of the books and articles referred to in the report. It is a list of the books and articles referred to in the report.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18902

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert B. Holden, Jr.				2. Date of Death Month Day Year June 10, 1999		3. Time of Death 6:57 A.M.	
	4a. Facility Name (If not institution, give street and number) 3605 Keene Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-14-9759		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) 07/13/1922	
	9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent								
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3605 Keene Avenue				10f. Zip Code 21214		10g. Citizen of What Country? United States		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Floral/Greenhouse			16b. Kind of Business/Industry Floral (self-employed)	
17. Father's Name (First, Middle, Last) Robert B. Holden, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Anna H. Kamtman				
19a. Informant's Name/Relationship (Type, Print) Dorothy H. Thompson/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1209, Easton, Maryland 21601				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Data 06/14/99		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee <i>Christina L. David</i>				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Contact gunshot wound of the head</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <u>Limited</u> 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 6-10-99		28b. Time of Injury 0645 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <u>subject shot self</u>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>Residence</u>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>3605 Keene Avenue Baltimore City, Maryland</u>				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 10, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Stephen S. Radentz</u> <u>111 Penn Street, Baltimore, Maryland 21201</u>								
31. Date filed (Month, Day, Year) <u>JUN 14 1999</u>				32. Registrar's Signature <i>B. Sparks</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#28a,28b per Phy G772 6/14/99 EW

Certificate of Death

Reg. No.

99 18903

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Cecil Harp</u>				2. Date of Death Month <u>June</u> Day <u>06</u> Year <u>1999</u>		3. Time of Death <u>11:30 AM</u>										
	4a. Facility Name (If not institution, give street and number) <u>Good Samaritan Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>Baltimore City</u>										
Funeral Director	5. Social Security Number <u>349-20-3796</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>73</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>April 8, 1926</u>	9. Birthplace (State or Foreign Country) <u>Pennsylvania</u>									
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State <u>Maryland</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Parkville</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	10e. Street and Number <u>27 Carriage Walk Court</u>				10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>United States</u>										
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>Korean</u> If Yes, Give Year or Dates: <u>WWII</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>										
	15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>12 Years</u> <u>College (1-4 or 5+)</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Welder</u>		16b. Kind of Business/Industry <u>Automobile Manufacture</u>										
	17. Father's Name (First, Middle, Last) <u>Oscar Jonathan Harp</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Edna Bertha Lyle</u>												
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Mrs. Karen Cordell/Daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>27 Carriage Walk Court Parkville, MD 21234</u>												
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Hilltop Service Corp.</u>		Date <u>6/10/99</u>		20c. Location - City or Town, State <u>Towson, Maryland</u>										
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Duda-Ruck Funeral Home of Dundalk, Inc.</u> <u>7922 Wise Ave. Dundalk, Maryland 21222</u>												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><u>Respiratory Failure</u></td> <td rowspan="4">Approximate interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td><u>Spinal Cord Injury</u></td> </tr> <tr> <td>c.</td> <td><u>Cervical 5-6 Subluxation after fall</u></td> </tr> <tr> <td>d.</td> <td><u>Ankylating Spondylitis</u></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	<u>Respiratory Failure</u>	Approximate interval Between Onset and Death	b.	<u>Spinal Cord Injury</u>	c.	<u>Cervical 5-6 Subluxation after fall</u>	d.
Immediate Cause (Final disease or condition resulting in death)	a.	<u>Respiratory Failure</u>	Approximate interval Between Onset and Death														
	b.	<u>Spinal Cord Injury</u>															
	c.	<u>Cervical 5-6 Subluxation after fall</u>															
	d.	<u>Ankylating Spondylitis</u>															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>Hospital</u>															
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <u>May 3, 1999</u>		28b. Time of Injury <u>Unknown</u> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <u>Fall while Fishing</u>									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D47474</u>		29d. Date signed (Month, Day, Year) <u>June 08, 1999</u>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>5601 Loch Raven Blvd. Suite 403/POB Baltimore MD 21239</u>																	
31. Date filed (Month, Day, Year) <u>JUN 14 1999</u>		32. Registrar's Signature <u>[Signature]</u>															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

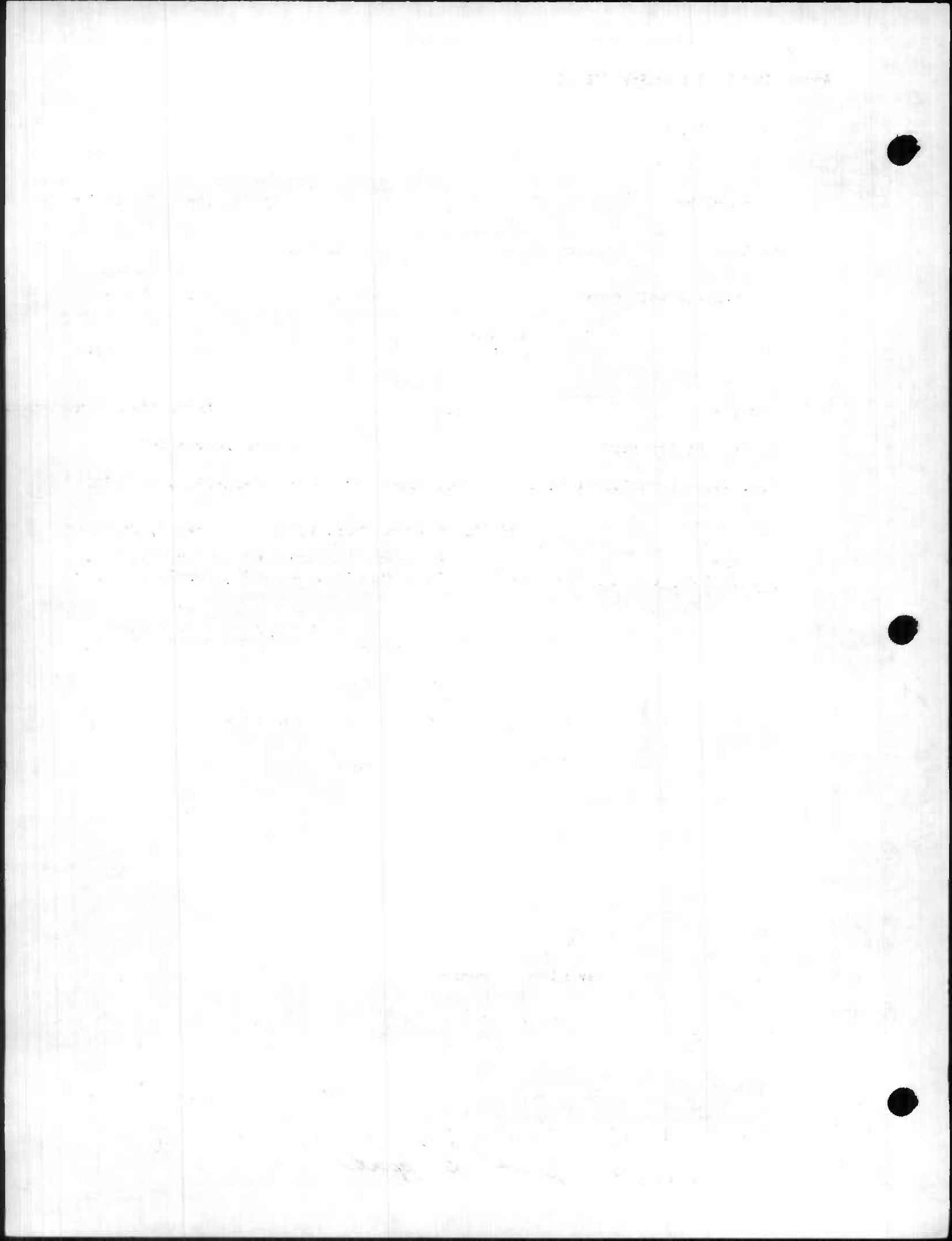
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18904

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

GORDON

HIMELFARB

2. Date of Death

Month Day Year
JUNE 4, 1999

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

214-18-6913

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 10, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6121 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4 Collage (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

MOE

HIMELFARB

18. Mother's Name (First, Middle, Maiden Surname)

SARA

REINER

19a. Informant's Name/Relationship (Type, Print)

SHELDON HIMELFARB / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13129 BRUSHWOOD WAY - POTOMAC, MD 20854

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

SHAAREI TFILOH CEMETERY

Date

6/9/99

20c. Location - City or Town, State

WOODLAWN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Myocardial infarction

Immediate

Due to (or as a consequence of):

b. Arteriosclerotic heart disease

Due to (or as a consequence of):

c. Diabetes Mellitus, type II

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?
☐ Yes ☒ NoHospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Burt I. Feldman MD

29c. License number

D23958

29d. Date signed (Month, Day, Year)

6/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burt I. Feldman MD, 6105 Montrose Rd, Rockville, MD 20852

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

B. Sparks

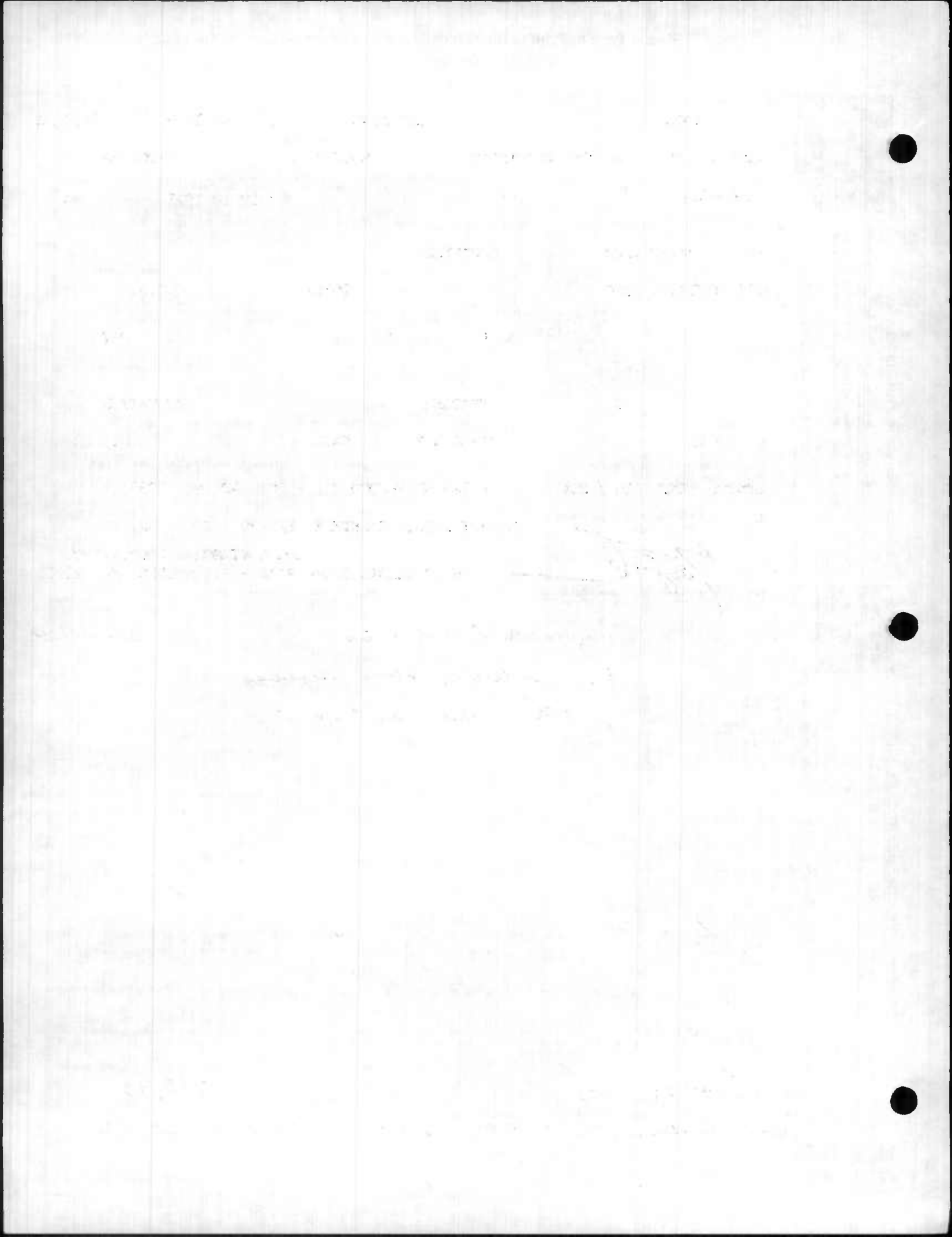
State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18995

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lucy Hastings-De Gutierrez</i>				2. Date of Death Month <i>June</i> Day <i>11</i> Year <i>1999</i>		3. Time of Death <i>8:10 AM</i>																					
	4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death																					
Funeral Director	5. Social Security Number <i>003-03-2780</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>82</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>03/13/1917</i>																					
	9. Birthplace (State or Foreign Country) <i>New Hampshire</i>																											
Usual Residence of Decedent																												
10a. State <i>Costa Rica</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Heredia</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
10e. Street and Number <i>P.O. Box 411 3000 Heredia</i>				10f. Zip Code <i>N/A</i>		10g. Citizen of What Country? <i>United States</i>																						
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>																					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4 years</i> College (1-4 or 5+) <i>4 years</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Plant Pathologist</i>			16b. Kind of Business/Industry <i>Botany</i>																					
17. Father's Name (First, Middle, Last) <i>Alfred B. Hastings</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Helen Fellows</i>																								
19a. Informant's Name/Relationship (Type, Print) <i>Mario Gutierrez / Spouse</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P.O. Box 411 300 Heredia, Costa Rica, Central America</i>																								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenmount Crematorium</i>		Date <i>6/12/99</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>																					
21. Signature of Funeral Service Licensee <i>David J. Weber</i>				22. Name and Address of Facility <i>David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231</i>																								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																												
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><i>Cerebrovascular Accident</i></td> <td><i>6 days</i></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><i>Subarachnoid Hemorrhage</i></td> <td><i>16 days</i></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a.	<i>Cerebrovascular Accident</i>	<i>6 days</i>	Due to (or as a consequence of):			b.	<i>Subarachnoid Hemorrhage</i>	<i>16 days</i>	Due to (or as a consequence of):			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.			d.		
Immediate Cause (Final disease or condition resulting in death)	a.	<i>Cerebrovascular Accident</i>	<i>6 days</i>																									
	Due to (or as a consequence of):																											
	b.	<i>Subarachnoid Hemorrhage</i>	<i>16 days</i>																									
	Due to (or as a consequence of):																											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.																											
	d.																											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																						
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																												
29b. Signature and title of certifier <i>Mark Wahl MD</i>				29c. License number <i>RES-000</i>		29d. Date signed (Month, Day, Year) <i>June 11, 1999</i>																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mark Wahl, MD Johns Hopkins Hospital</i>																												
31. Date filed (Month, Day, Year) <i>JUN 14 1999</i>		32. Registrar's Signature <i>[Signature]</i>																										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18906

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

IRVING ANTHONY HANNAH

2. Date of Death
Month Day Year

MAY 29 1999

3. Time of Death

22-35H2

4a. Facility Name (If not institution, give street and number)

ER HAFOND MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

HAUGSDE GRACE HAFOND

4c. County of Death

Funeral
Director

5. Social Security Number

214-08-3585

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC 31, 1956

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State
MD

10b. County

Hartford

10c. City, Town or Location

Haug's Grace, MD

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Union Ave

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTODIAN

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Eugene Hannah

18. Mother's Name (First, Middle, Maiden Surname)

Helen Handersdale

19a. Informant's Name/Relationship (Type, Print)

Helen Hannah Handersdale

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Union Ave. Haug's Grace, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

STANISLUS CEM

Date

6-4-99 Haug's Grace, MD 21078

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

5500 Union Ave. Haug's Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis Liver

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] DME

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MAY 29 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRABHU MD 218 BILFORD AVE BELAIR MD 21014

31. Date filed (Month, Day, Year)

JUN 11 1999

32. Registrar's Signature

[Signature] B. Sparks

State
Registrar

5-29-99 2235 Dr Prabh-527-0168 Home

Baltimore, Maryland 21215-0020 879-6564

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Hannah, Irving Anthony
Division of Vital Records, P.O. Box 68760,

AH2

x

10

Eugene Harnish
John Harnish and Co.

2nd

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#7 PAPER F.H., 6/14/99, G772, gap

Certificate of Death

Reg. No. 99 18907

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) WILLIAM JACKSON						2. Date of Death Month Day Year JUNE 8, 1999		3. Time of Death 4:30pm	
	4a. Facility Name (If not institution, give street and number) 8631 WINANDS ROAD						4b. City, Town, or Location of Death N/A		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 248-14-2386		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) 12/22/19		9. Birthplace (State or Foreign Country) WINSBORO, SC	
	Usual Residence of Decedent									
10e. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 8631 WINDANDS ROAD				10f. Zip Code 21133		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELFEMPLOYED				16b. Kind of Business/Industry HANDYMAN		
17. Father's Name (First, Middle, Last) WILLIAM JACKSON						18. Mother's Name (First, Middle, Maiden Surname) LUCILLE JACKSON				
19a. Informant's Name/Relationship (Type, Print) GAIL FORD (DAUGHTER)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8631 WINANDS RD, RANDALLSTOWN, MD 21133				
20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		Date 6-15-99		20c. Location - City or Town, State BALTIMORE, MD			
21. Signature of Funeral Service Licensee <i>William Howell</i>						22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardio-pulmonary arrest Due to (or as a consequence of): b. Carcinoma of lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>William Howell</i>						29c. License number 026585		29d. Date signed (Month, Day, Year) June 10, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Avata MD 6509 N. Charles Street Towson MD 21204										
31. Date filed (Month, Day, Year) JUN 14 1999			32. Registrar's Signature <i>Seneca B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

174-2 17-1

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18908

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) William Alfred Johnson				2. Date of Death Month Day Year May 10 1999		3. Time of Death 2000	
4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
5. Social Security Number 220-09-0521		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 28 1916	
9. Birthplace (State or Foreign Country) MARYLAND							
10a. State MARYLAND		10b. County QUEEN ANNE		10c. City, Town or Location CENTERVILLE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 112 KING COURT				10f. Zip Code 21617		10g. Citizen of What Country? US	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PLUMMER		16b. Kind of Business/Industry DUNTON & SONS			
17. Father's Name (First, Middle, Last) WILLIAM W. JOHNSON				18. Mother's Name (First, Middle, Maiden Surname) BERTHA HOY			
19a. Informant's Name/Relationship (Type, Print) VIOLA I. JOHNSON (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 KING CT. CENTERVILLE, MD. 21617			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HILL CREST CEMETERY		Date 5/17/99		20c. Location - City or Town, State ANNAPOLIS, MD.	
21. Signature of Funeral Service Licensee <i>Larry H. Reese</i>				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>CARDIOpulmonary Arrest</i> Due to (or as a consequence of): b. <i>Renal Failure</i> Due to (or as a consequence of): c. <i>Dehydration</i> Due to (or as a consequence of): d. <i>Citronic Subdural</i>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Senile Dementia, Hypertension, Poor Equilibrium with multiple Falls</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) UNKNOWN		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Charles M.D.</i>				29c. License number 023889		29d. Date signed (Month, Day, Year) 5/18/99	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John C. ARRABAL M.D., 948 Washington Ave, Chestertown							
31. Date filed (Month, Day, Year) JUN 14 1999				32. Registrar's Signature <i>Seneca B. Sparks</i>			

To Be Completed by Funeral Director

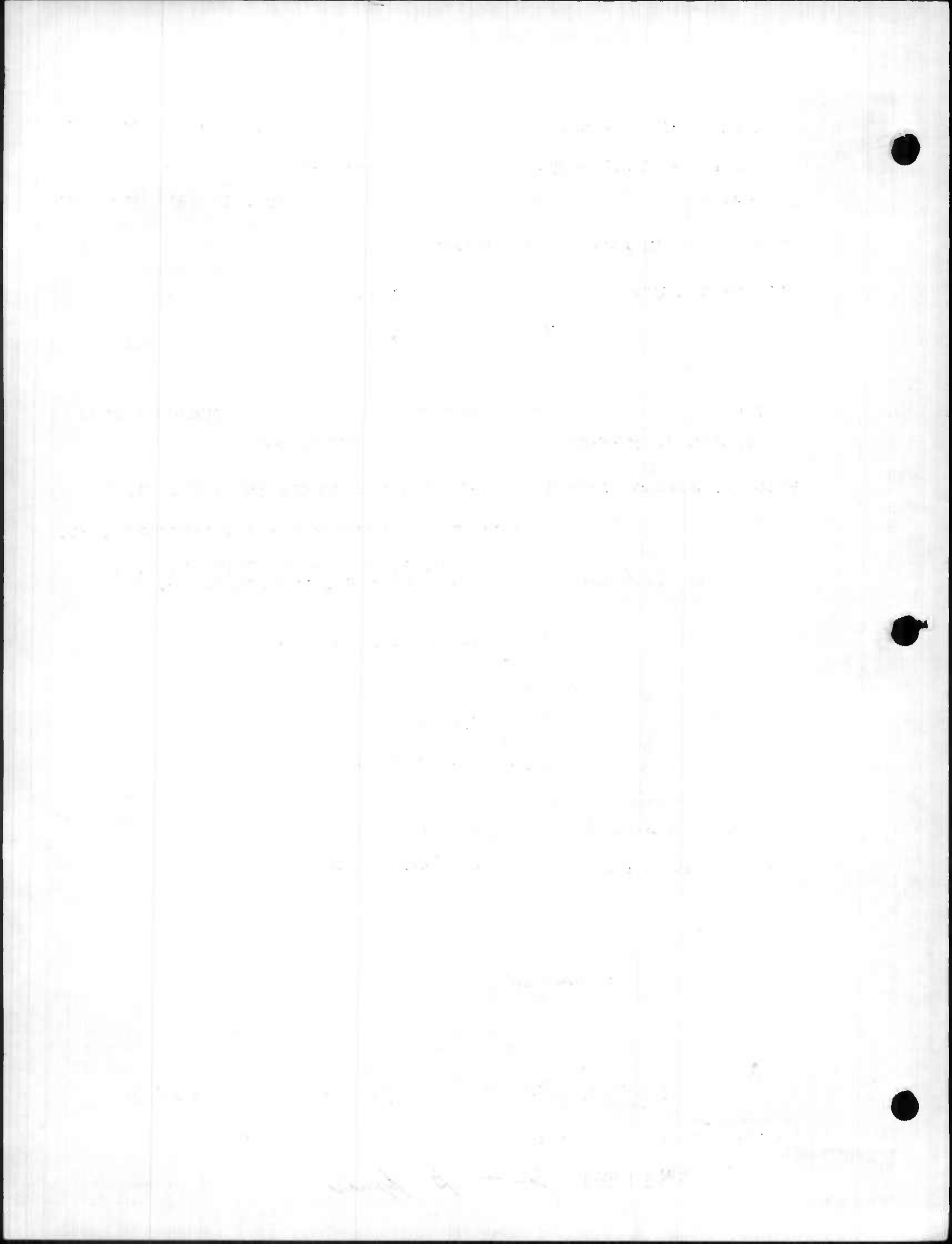
To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18909

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) INEZ King		2. Date of Death Month Day Year June 9 1999		3. Time of Death 10:55 PM	
4a. Facility Name (If not institution, give street and number) St. Agnes Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
5. Social Security Number 249-70-6119		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 98	
Usual Residence of Decedent		8. Date of Birth (Month, Day, Year) DEC. 12, 1900		9. Birthplace (State or Foreign Country) S. CAROLINA	
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 22 South Athol Ave.		10f. Zip Code 21229	
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry Private Family		17. Father's Name (First, Middle, Last) Ed. PIERCE	
18. Mother's Name (First, Middle, Maiden Surname) ELLA		19a. Informant's Name Relationship (Type, Print) RAY Robinson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3014 Reisterstown Rd. Balt. Md 21215	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State Baltimore, Md.	
21. Signature of Funeral Service Licensee Blanca Adams		22. Name and Address of Facility MARSHALL W. JONES JR. R.H. PA 4101 Edmondson Ave. Baltimore 21229		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS	
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):		Approximate Interval Between Onset and Death 1 Day	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):			
		Due to (or as a consequence of):			
		Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier Chubasco Munkala, MD		29c. License number D46704		29d. Date signed (Month, Day, Year) June 9, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUTUMBO KANKORDE ST AGNES HOSPITAL BLT MD					
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature J. Sparks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

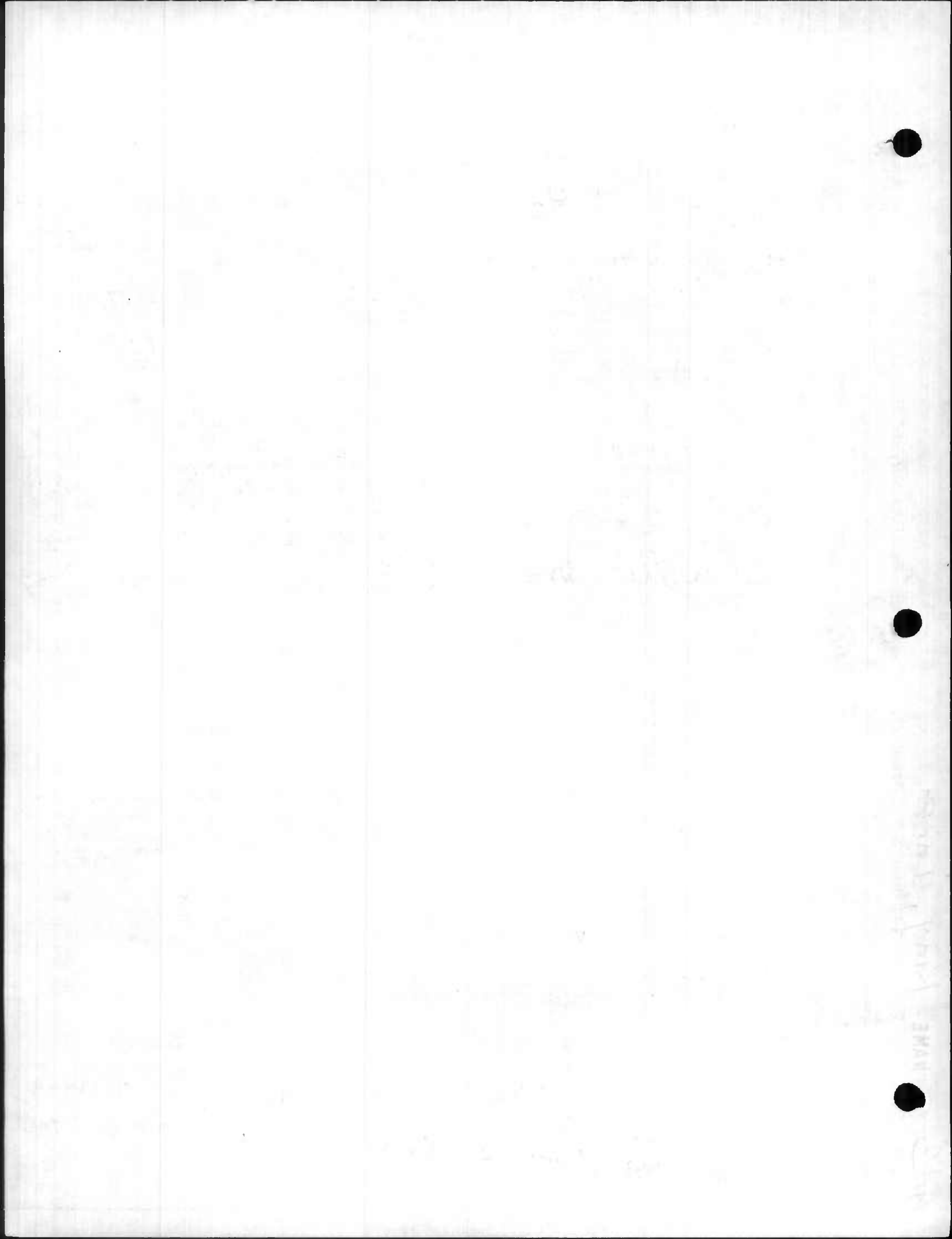
NAME King, Inez

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in full in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18910

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Fannie Kagen

2. Date of Death

Month
JuneDay
8Year
99

3. Time of Death

11:15 AM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

100-24-3005

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
FEB 17, 1927

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6336 CEDAR LANE, APT. 368

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

MATHEMATICIAN

16b. Kind of Business/Industry

INSURANCE CO.

17. Father's Name (First, Middle, Last)

BERNARD

HERSCHLAG

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE

KLEIN

19a. Informant's Name/Relationship (Type, Print)

MRS. BARBARA SWITZER (DAUG.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7278 POMMEL DR. SYKESVILLE, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MIKRO KODESH-BETH ISRAEL

Date

6/10/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD.

PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cerebrovascular Accident
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Meningeal, Hypertension, Status Epilepticus
Coronary artery Disease, Aspiration Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

F. DeLeon

29c. License number

046120

29d. Date signed (Month, Day, Year)

June 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

F DeLeon

10724 Little Patuxent Pkwy, Columbia, MD 21044

State
Registrar

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18911

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) SIGMUND R. KALLINS		2. Date of Death Month Day Year JUNE 8 1999		3. Time of Death 5:30 AM	
4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
5. Social Security Number 213-01-8766	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB 13, 1906
9. Birthplace (State or Foreign Country) MARYLAND					
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6300 PIMLICO RD.			
10f. Zip Code 21209		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ATTORNEY		16b. Kind of Business/Industry AT LAW			
17. Father's Name (First, Middle, Last) MORDECHAI KALLINS			18. Mother's Name (First, Middle, Maiden Surname) BERTHA FOX		
19a. Informant's Name/Relationship (Type, Print) VERA KALLINS(WIFE)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6300 PIMLICO RD. BALTIMORE, MD 21209		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEBREW FRIENDSHIP		20c. Location - City or Town, State 6/10/99 BALTIMORE, MD	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D 37254		29d. Date signed (Month, Day, Year) 6/8/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204					
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18912

ITEM: #26 PER F.H. G772 6-14-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie M. Kucinski				2. Date of Death Month Day Year 06 09 1999				3. Time of Death 11:15 a.m.		
	4a. Facility Name (If not institution, give street and number) 1002 Edmondson Avenue				4b. City, Town, or Location of Death Catonsville				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 214-03-7942		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) 08 14 1916		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent				10a. State Md				10b. County		10c. City, Town or Location Baltimore
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 3310 Benson Avenue Apt 214				10f. Zip Code 21227		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Anthony Szczybor				18. Mother's Name (First, Middle, Maiden Surname) Stephanie Koros						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Regina Simon/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 538 Stratford Road, Fallston, Md 21047						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary		Date 6/12/99		20c. Location - City or Town, State Baltimore, Md.				
	21. Signature of Funeral Service Licensee Mayk. Marshall				22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Baltimore, Md. 21228						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory Insufficiency</u> Due to (or as a consequence of): b. <u>Interstitial pulmonary disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death weeks weeks						
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hens				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) DAUGHTER'S RESIDENCE						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier M. Schenck MD				29c. License number D-40521		29d. Date signed (Month, Day, Year) June 10, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. OCHANEY				7845 Oakwood Road Suite 205 Green Spring, MD 21061							
31. Date filed (Month, Day, Year) JUN 14 1999				32. Registrar's Signature Diana S. Sparks							

ORIGINAL

2000 1.18.07

ADH
DELORIS LASHLEY
99-3323510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART 1, 27 PER MEO G773 7-14-99 WR.

Certificate of Death

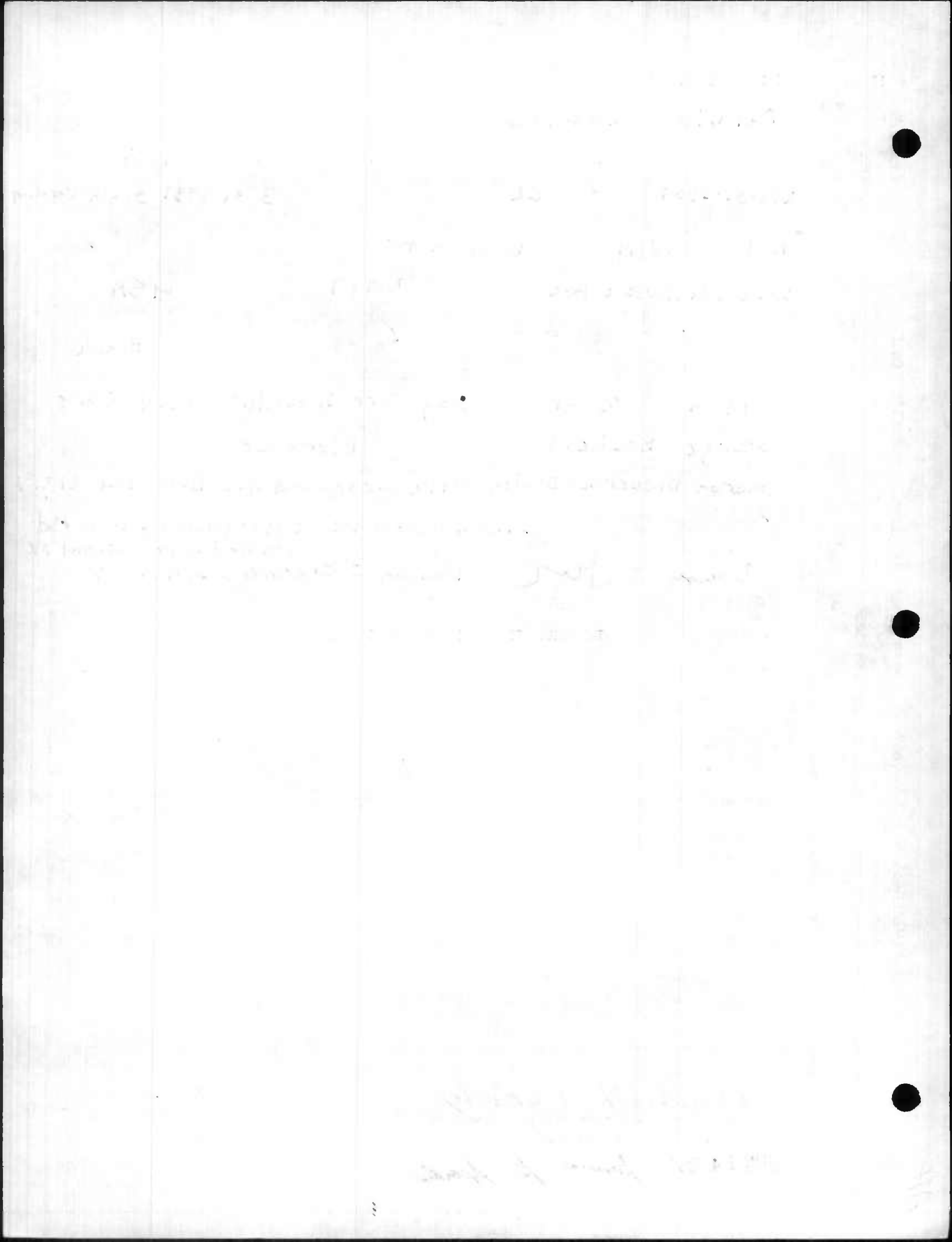
Reg. No.

99 18913

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Deloris Lashley				2. Date of Death Month Day Year JUNE 11, 1999		3. Time of Death 1855 PM			
	4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death NIA			
Funeral Director	5. Social Security Number 251-56-6307		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year 3 31 1937			
	9. Birthplace (State or Foreign, Country) South Carolina		Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State md		10b. County NIA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2112 Westwood Ave				10f. Zip Code 21217		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 2 yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Day Care Provider			16b. Kind of Business/Industry Child Care				
	17. Father's Name (First, Middle, Last) George Beckert				18. Mother's Name (First, Middle, Maiden Surname) Florence					
	19a. Informant's Name/Relationship (Type, Print) Sharon Dickerson Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2112 Westwood Ave Balto Md 21217					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garnson Forest Mt		20c. Date 6-11-99		20d. Location - City or Town, State owning mnt Md			
	21. Signature of Funeral Service Licensee Vaughn C Green				22. Name and Address of Facility 5151 Baltimore National Ave Vaughn C Greene Funeral Ser					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Stephen S. Radentz				29c. License number OCME		29d. Date signed (Month, Day, Year) JUNE 12, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JUN 14 1999				32. Registrar's Signature B. B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18914

Amended Items#25,26,27 perPhyG772 6/14/99 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Lemmon				2. Date of Death Month Day Year May 20 1999		3. Time of Death 7:02 p.m.											
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery											
Funeral Director	5. Social Security Number 249-12-2202		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) July 19, 1912											
	9. Birthplace (State or Foreign Country) S. Carolina		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring											
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2601 Bell Pre Road		10f. Zip Code 20906		10g. Citizen of What Country? U.S.A.											
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry Railroad													
	17. Father's Name (First, Middle, Last) George Lemmon				18. Mother's Name (First, Middle, Maiden Surname) Fannie													
	19a. Informant's Name/Relationship (Type, Print) Montgomery General Hospital				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18101 Prince Phillip Dr., Olney, MD 20832													
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) in state		20c. Location - City or Town, State in state													
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director <i>Ronald S. Wade</i>				22. Name and Address of Facility State Anatomy Board, 655 w. Baltimore Street Baltimore, MD 21201													
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Aspiration Pneumonia Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 1 week</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. Hepatic Cirrhosis Due to (or as a consequence of):</td> <td>6 months</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 week	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Hepatic Cirrhosis Due to (or as a consequence of):	6 months	c. _____ Due to (or as a consequence of):		d. _____ Due to (or as a consequence of):	
	Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 week															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Hepatic Cirrhosis Due to (or as a consequence of):	6 months																
	c. _____ Due to (or as a consequence of):																	
	d. _____ Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown												
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
29b. Signature and title of certifier Amendurullo MD				29c. License number D38262		29d. Date signed (Month, Day, Year) May 23 1999												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Menchiratta 2401 Research Blvd Suite 340 Rockville MD 20850																		
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature James B. Sparks																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

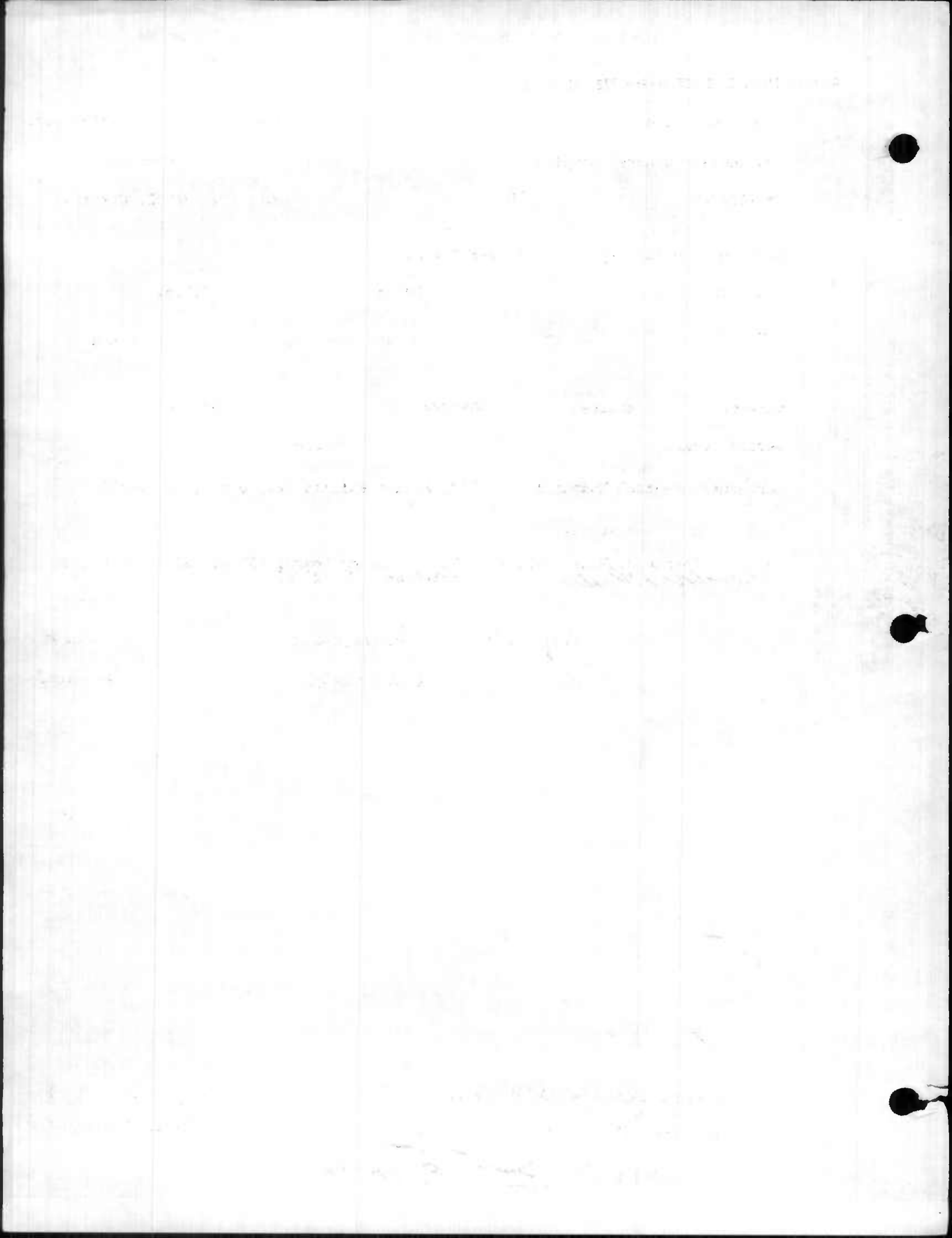
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in full in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18915

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances L Bianca Lucido			2. Date of Death Month June Day 10 Year 1999		3. Time of Death 10:58 pm	
	4a. Facility Name (If not institution, give street and number) Ridgeway Manor N.H.-5743 Edmondson			4b. City, Town, or Location of Death Baltimore, Md.		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-05-3000		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) 12/05/02
	9. Birthplace (State or Foreign Country) Italy		10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 516 Rock Glen Road		10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tailor		16b. Kind of Business/Industry Clothing			
17. Father's Name (First, Middle, Last) Joseph Lucido			18. Mother's Name (First, Middle, Maiden Surname) Rose Presti				
19a. Informant's Name/Relationship (Type, Print) S. Robert Bianca (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 628 Aldershot Road, Baltimore, Maryland 21229				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral		Data 6/15/99		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee Rhet Sykes Behm			22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228				
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary edema Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last COPD							Approximate Interval Between Onset and Death 5 minutes 8 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Damian E. Birchess MD			29c. License number 022114			29d. Date signed (Month, Day, Year) 6/12/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAMIAN E. BIRCHESS MD 5411 OLD FREDERICK ROAD, SUITE 19, BALTIMORE, MD 21219							
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature P. Sparks					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18916

AMEND ITEM: 5 PER F.H. G773 7-8-99 WR.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALDONIA MALONE

2. Date of Death

Month Day Year
6 11 99

3. Time of Death

6:45 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

212-32-3015

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 4, 1907

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State
Maryland

10b. County

BALTIMORE

10c. City, Town or Location

REISTERSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

610 St. Georges Station Road

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private family

17. Father's Name (First, Middle, Last)

ALBERT Coleman

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE JONES

19a. Informant's Name/Relationship (Type, Print)

DORIS M. Crawford

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

610 St. Georges Station Road REISTERSTOWN, MD 21136

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of
cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

6-18-99

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

Dorothy Harris

22. Name and Address of Facility

CHATHAM - HARRIS F.H.
5240 REISTERSTOWN ROAD
BALTIMORE, Maryland 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Respiratory failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Bil. Pneumonia

Due to (or as a consequence of):

5 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DM II

HTN

S/P PEG

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. K. Turalchia, M.D.

29c. License number

D36942

29d. Date signed (Month, Day, Year)

6/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BIPIN K. TURALCHIA, M.D. 5401 OLD COURT RD RANDALLSTOWN, MD

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

B. K. Turalchia

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a pt1 C perPhyG772 6/14/99 EW

Certificate of Death

Reg. No.

99 18917

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) HENRY		2. Date of Death Month JUNE Day 05 Year 1999		3. Time of Death 7:00AM	
4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 215-28-2810		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 67	
8. Date of Birth (Month, Day, Year) Jan. 9, 1932		9. Birthplace (State or Foreign Country) Delaware			
Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
10d. Inside City Limits 1 Yes 2 No					
10e. Street and Number 8014 Midhaven Road		10f. Zip Code 21222		10g. Citizen of What Country? United States	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes Mexican	
14. Race - American Indian, Black, White, etc. Hispanic					
15. Decedent's Education (Specify only highest grade completed) 12 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry Steel Industry	
17. Father's Name (First, Middle, Last) Vincent Mendez		18. Mother's Name (First, Middle, Maiden Surname) Elvira Juarez			
19a. Informant's Name/Relationship (Type, Print) Wife Mrs. Deanna D. Mendez		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8014 Midhaven Road Dundalk, Maryland 21222			
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. 6/8/1999		20c. Location - City or Town, State Towson, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. VENTRICULAR FIBRILLATION ARREST Due to (or as a consequence of): f. ANOXIC BRAIN INJURY Due to (or as a consequence of): g. CORONARY ARTERY DISEASE Due to (or as a consequence of): h. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 9 DAYS 9 DAYS 10 Years			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
24a. Were en autopsies performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M	
28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Alan M. Weiss MD		29c. License number 98033		29d. Date signed (Month, Day, Year) JUNE 5, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan M. Weiss MD Johns Hopkins Bayview Medical Center Balto. MD. 21224					
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature James B. Sparks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

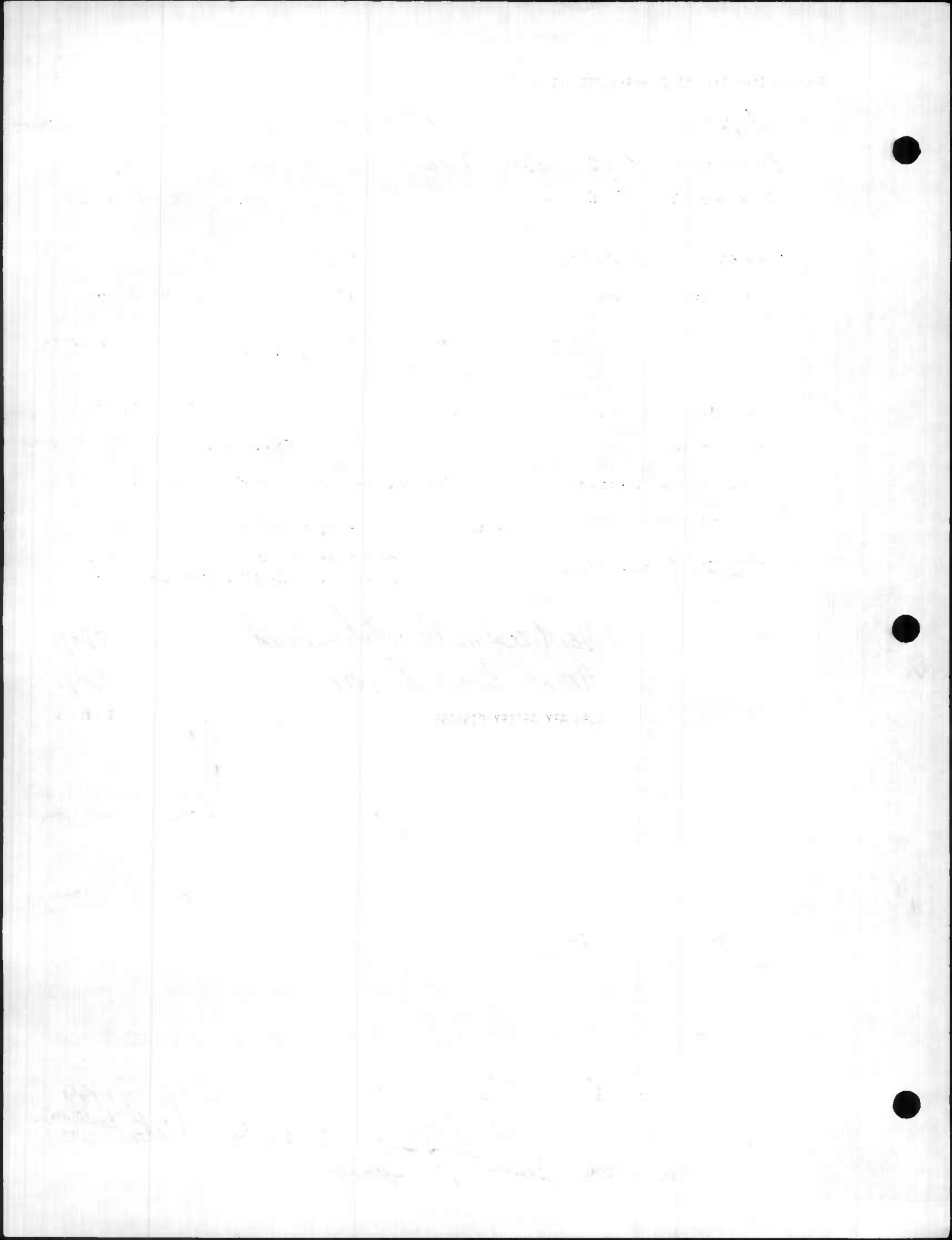
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

20

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18918

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Willard J. Mitchell

2. Date of Death
Month Day Year

June

10

1999

3. Time of Death

2:25 PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

220-20-0907

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 28, 1929

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Millersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8222 Railroad Avenue

10f. Zip Code

21108

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

Union Local

17. Father's Name (First, Middle, Last)

Holly W. Mitchell

18. Mother's Name (First, Middle, Maiden Surname)

Ada Elisie Fawley

19a. Informant's Name/Relationship (Type, Print)

Nellie P. Mitchell - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8222 Railroad Avenue, Millersville, MD 21108

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cemetery

Date

June 14 Glen Burnie, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Institution

22. Name and Address of Facility

Stallings Funeral Home, P.A.
3111 Mountain Road, Pasadena, MD 21122

23. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MASSIVE UPPER GASTROINTESTINAL BLEEDING.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CEREBROVASCULAR ACCIDENT.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Aspeton

MD.

29c. License number

D43977

29d. Date signed (Month, Day, Year)

June 10 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angela Okatunji, 301 Hospital Drive, Glen Burnie, MD. 21061

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

J. Spawth

State
Registrar

Mitchell, Willard

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

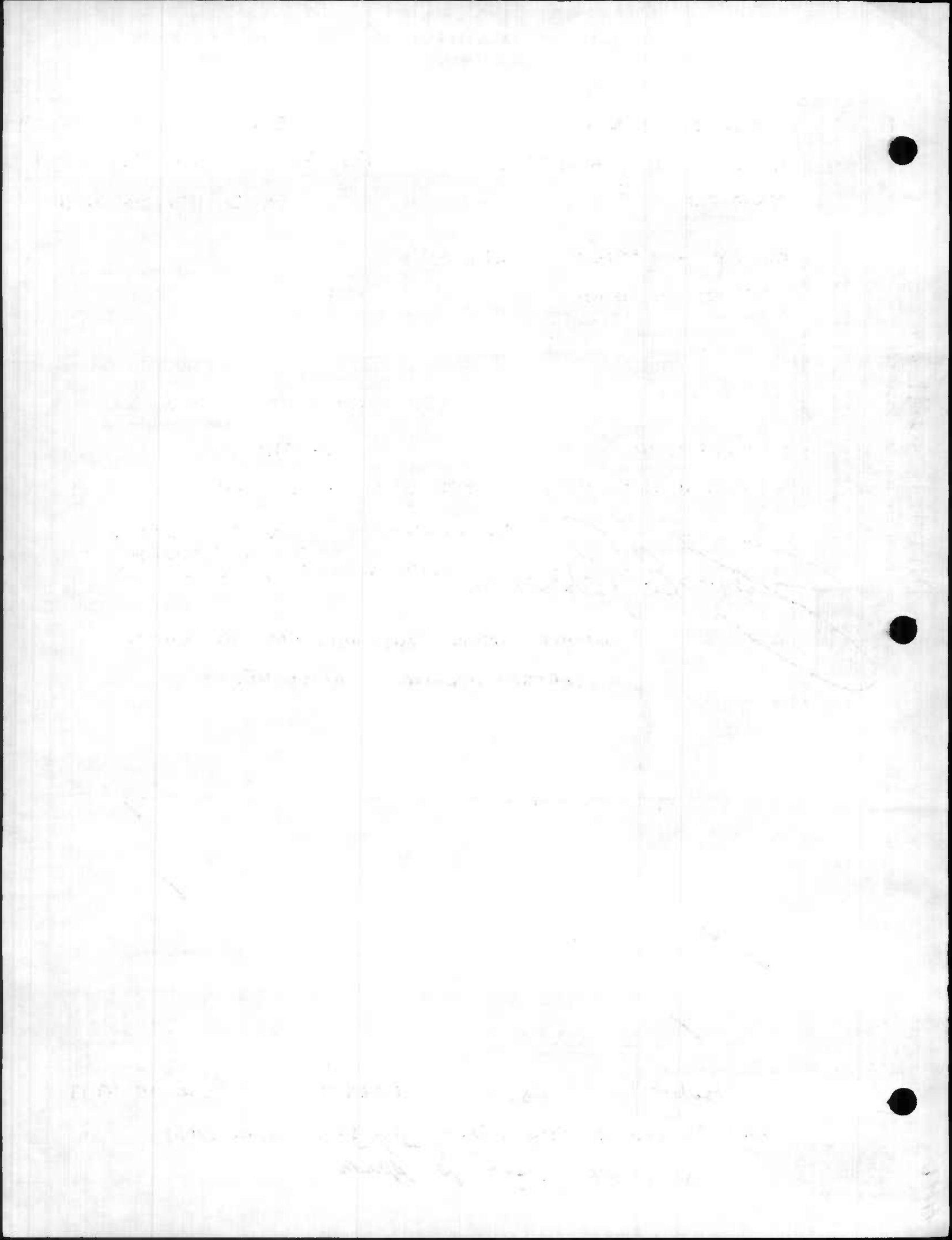
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18919

Amended Item#24a perPhyG772 6/14/99 EW

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Ruth M. Myers		2. Date of Death Month May Day 22 Year 1999		3. Time of Death 2:55 p.m.	
4a. Facility Name (If not institution, give street and number) National Lutheran Home			4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery
5. Social Security Number 129-30-8378	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) July 16, 1911	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent					
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Rockville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9701 Veirs Drive		10f. Zip Code 20901		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Microbiologist		16b. Kind of Business/Industry Medical			
17. Father's Name (First, Middle, Last) James W. Myers			18. Mother's Name (First, Middle, Maiden Surname) Adele B. Fosler		
19a. Informant's Name/Relationship (Type, Print) Janet Strube/sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65 St. John Circle, Lititz, PA. 17543		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of): Atherosclerosis Due to (or as a consequence of): Hypertension Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Chronic Obstructive Pulmonary Disease					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier [Signature]		29c. License number 033138		29d. Date signed (Month, Day, Year) May 23, 1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Daniel A. Jaller MD 12850 Middlebrook Rd, Germantown, MD					
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature [Signature]			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18920

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NAOMI GLADYS MCCLUNG				2. Date of Death Month Day Year June 9 1999		3. Time of Death 22:30 PM	
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 216-12-7965		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) 8/15/1908	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 815 WINTERS LANE APT 307		10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PARTNERSHIP		16b. Kind of Business/Industry ASSOCIATED ELECTRIC SERVICE COMPANY			
	17. Father's Name (First, Middle, Last) JOSEPH R. FUNK				18. Mother's Name (First, Middle, Maiden Surname) ANNIE B. (WEITZEL)			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ROBERT MCCLUNG (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 CEDARCROFT ROAD BALTIMORE, MD 21212			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEM. PARK		20c. Location - City or Town, State ELKRIDGE, MD		20d. Date 6/14/99	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. SEPSIS Due to (or as a consequence of): 4 Days f. PERITONITIS Due to (or as a consequence of): 4 Days g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						24a. Were an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number D52540		29d. Date signed (Month, Day, Year) June 10, 1999	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Thomas J. Enelow St. Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JUN 14 1999				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

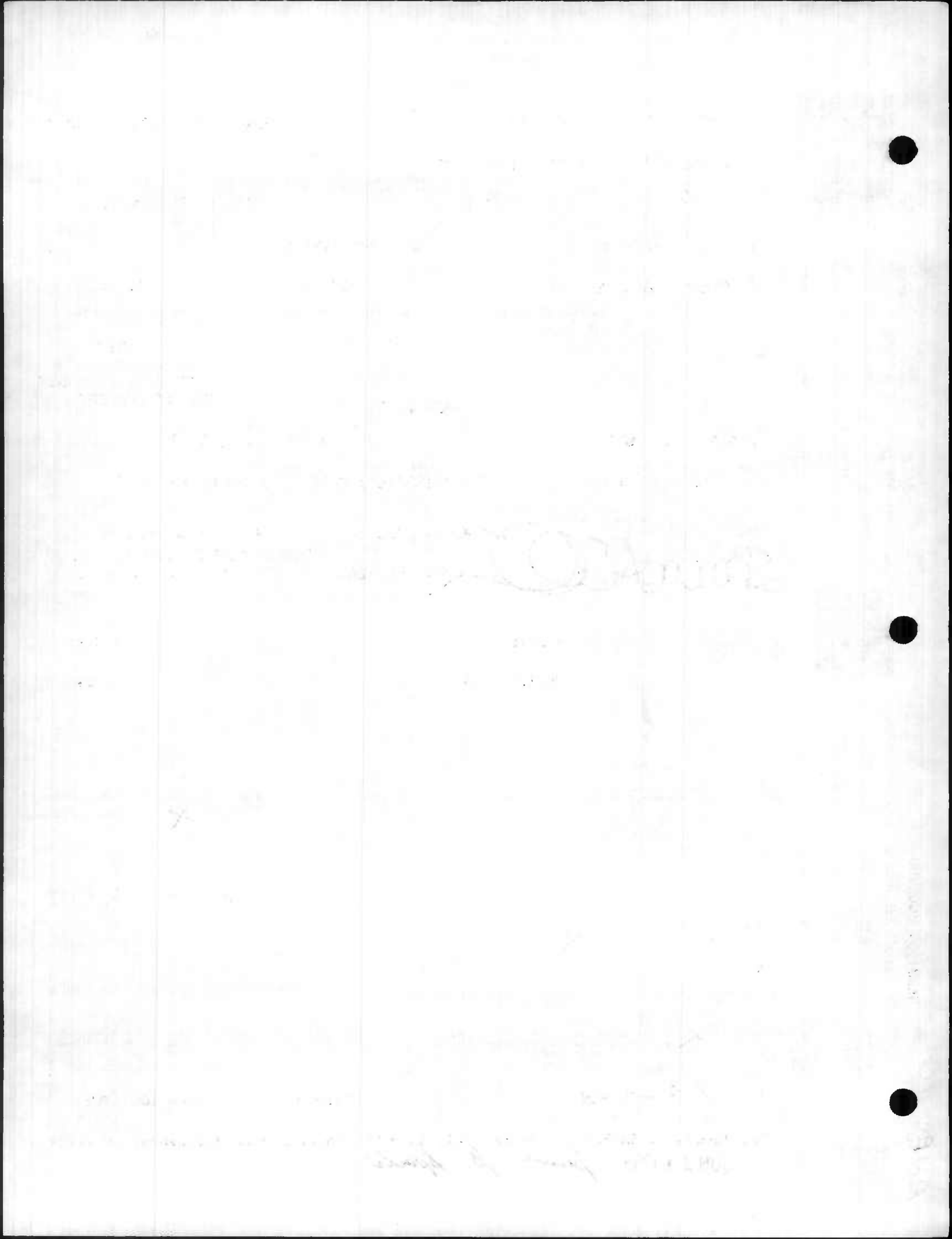
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

NAOMI G. MCCLUNG

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18921

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CARRIE PARKER

2. Date of Death

Month

Day

Year

6 10 99

3. Time of Death

11:45 AM

4a. Facility Name (If not institution, give street and number)

5207 LINDEN HGTS. AVE.

4b. City, Town, or Location of Death

BALTO.

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-03-0302

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9 13 1903

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

5207 Linden Hts Ave

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

High School

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Johnny Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Lula Williams

19a. Informant's Name/Relationship (Type, Print)

Sharon Johnson Granddaughter 5209 Linden Hts Ave Balto md 21215

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Park Cem

Date

6-14-99 Randallstown Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Vaughn C Green

22. Name and Address of Facility

5151 Baltimore National Pike

Vaughn C Greene Funeral Ser

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Dehydration
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Gangrene of foot
Due to (or as a consequence of):

6 months

c. Demons
Due to (or as a consequence of):

many yrs

d. Peripheral vascular disease

many yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Armon D Goldsby

29c. License number

033977

29d. Date signed (Month, Day, Year)

6/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Armon D Goldsby 6804 Park Heights Ave Balto Md 21215

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

Armon D Goldsby

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

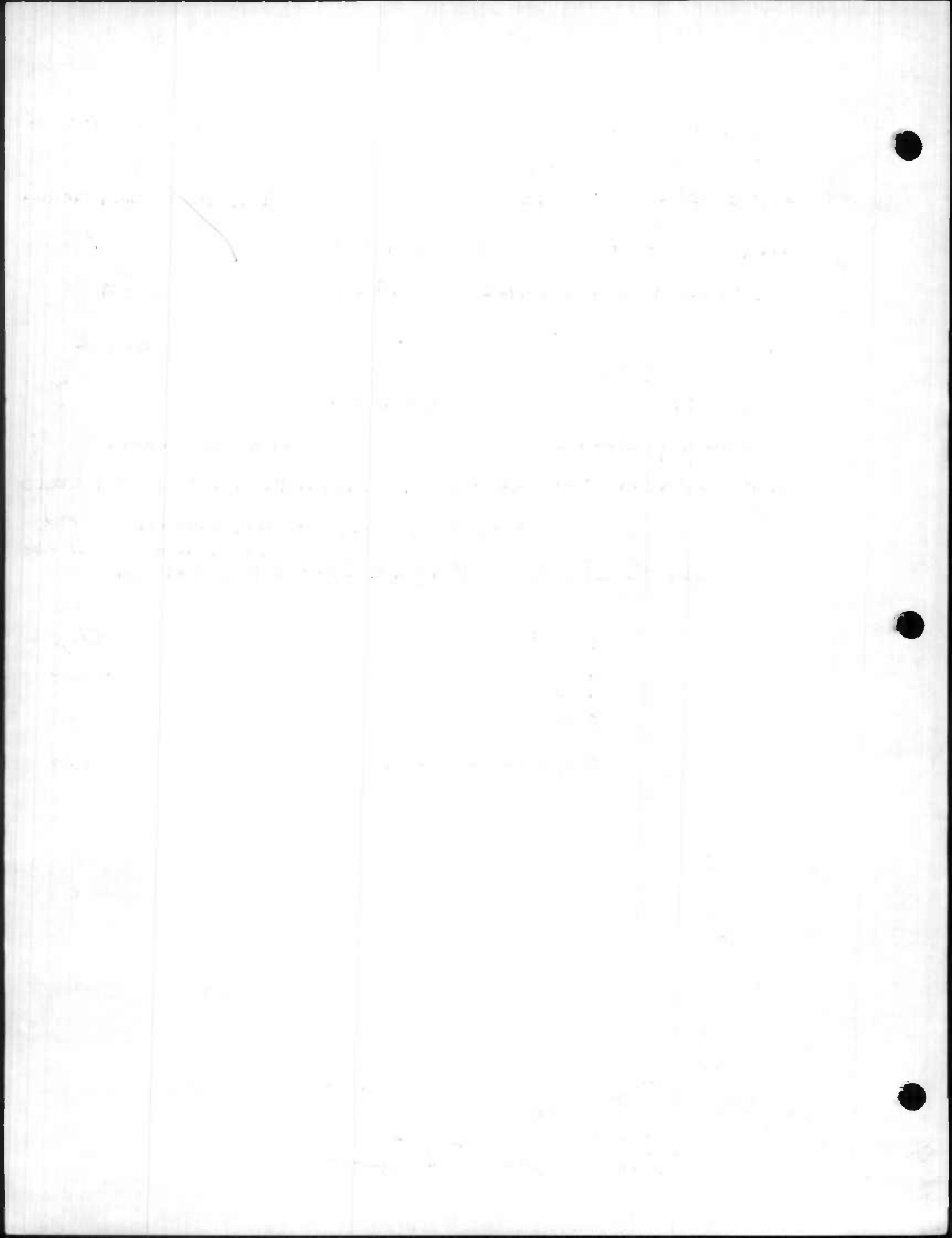
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18922

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rose M. Taylor

2. Date of Death

6 7 99

3. Time of Death

11:57 A.

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-34-5165

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2-11-38

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A.

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

123 W 29th St.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

-12-

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SWITCHBOARD OPERATOR

16b. Kind of Business/Industry

DEPARTMENT STORE

17. Father's Name (First, Middle, Last)

JOHN HOLLOMAN

18. Mother's Name (First, Middle, Maiden Summa)

ROSALIE DOLMAN

19a. Informant's Name/Relationship (Type, Print)

SHON S. SHANNON (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3036 REMINGTON AVE. BALTIMORE, MARYLAND

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

6-16-99 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Doretha Hector

CFSP

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.

1721-27 N. Monroe ST. BALTIMORE, MARYLAND

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cardiorespiratory arrest

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia

S/P CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

T. Kawaja

29c. License number

D25112

29d. Date signed (Month, Day, Year)

6/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tahoorah Kawaja m. D 1777 Reisterstown Rd Balto MD 21208

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

133-4-20-20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18923

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anthony Allan Phelps, III				2. Date of Death Month Day Year JUNE 12, 1999		3. Time of Death 0257 AM	
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER E.R.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 218-08-3187		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 20 Yrs.		8. Date of Birth (Month, Day, Year) April 23, 1979	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 374 Nicholson Road		10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction				
17. Father's Name (First, Middle, Last) Anthony A. Phelps				18. Mother's Name (First, Middle, Maiden Surname) Carol Antkowiak				
19a. Informant's Name/Relationship (Type, Print) Donald Antkowiak (Grandfather)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 374 Nicholson Road, Baltimore, Maryland 21221				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		Date 6/15/99		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee <i>John W. Bruckowski</i>				22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Multiple Myeloma</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6/12/99		28b. Time of Injury 0216 Hrs		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <i>Subject down vehicle, struck head</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>7000 Eastern Boulevard Baltimore Maryland</i>						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>Thomas M. King</i>						
29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JUNE 12, 1999						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE COOPER MCKIN 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature <i>Denise B. Sparks</i>						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18924

Amended Item#26 perPhyG772 6/14/99 EW

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVYN PUGATCH		2. Date of Death Month Day Year MAY 29, 1999		3. Time of Death 2:10 PM
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 217-20-9043	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) JUNE 26, 1919		9. Birthplace (State or Foreign Country) PA		
Usual Residence of Decedent					
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 7121 PARK HEIGHTS AVENUE #610			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REAL ESTATE DEVELOPER		16b. Kind of Business/Industry REAL ESTATE	
17. Father's Name (First, Middle, Last) BENJAMIN PUGATCH			18. Mother's Name (First, Middle, Maiden Surname) CELIA LUBIN		
19a. Informant's Name/Relationship (Type, Print) LORRAINE PUGATCH / WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7121 PARK HEIGHTS AVE. #610 - BALTIMORE, MD 21215		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO		20c. Location - City or Town, State 5/31/99 BALTIMORE, MD	
21. Signature of Funeral Service Licensee <i>Scott M. Cutler</i>		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKEVILLE, MD 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. Myocardial Infarct Due to (or as a consequence of):			Approximate Interval Between Onset and Death IMMEDIATE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Harry M. Walen</i>		29c. License number D10718		29d. Date signed (Month, Day, Year) 5/30/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRY M. WALEN MD 1838 GREENE TREE RD Ste 300 BALTIMORE MD 21208					
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature <i>James B. Sparks</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

IMMEDIATE

URGENT 11/11/68

21 NOV 68

21 NOV 68

11 NOV 68

11 NOV 68

11 NOV 68

11 NOV 68

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18925

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor Johanna Preston

2. Date of Death

Month Day Year
JUNE 12 1999

3. Time of Death

4:55 AM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

220-36-6753

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs./last birthday)

59

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Nov. 25, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Millersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8353 Brookwood Rd.

10f. Zip Code

21108

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Edward Ernest Mekins

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Catherine Pearce

19a. Informant's Name/Relationship (Type, Print)

Catherine A. Barrett / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 1, Box 170, Rowlesburg, VA 26425

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glen Haven Mem. Pk.

Date

June 15
1999

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home, P.A.

421 Crain Hwy., S.E., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Metastatic Pancreatic Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Yolanda M. ... MD

29c. License number

D46962

29d. Date signed (Month, Day, Year)

JUNE 12, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

M. SHIRAZI, M.D., NORTH ARUNDEL HOSPITAL, MD 21061.

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

Jenna B. Sparks

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18926

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILLIP E. RANDOLPH				2. Date of Death Month Day Year JUNE 7 1999		3. Time of Death 21:15																						
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A																						
Funeral Director	5. Social Security Number 218-82-2278		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 36 Yrs.		8. Date of Birth (Month, Day, Year) 11-12-62																						
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County N/A																						
To Be Completed by Funeral Director	10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																								
	10e. Street and Number 3722 EDMONDSON AVENUE				10f. Zip Code 21229		10g. Citizen of What Country? USA																						
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK																						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 TH GRADE College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) JANITOR		16b. Kind of Business/Industry HEALTH CARE																								
	17. Father's Name (First, Middle, Last) WILBUR RANDOLPH				18. Mother's Name (First, Middle, Maiden Surname) TINIE WHEELER																								
	19a. Informant's Name/Relationship (Type, Print) TINIE RANDOLPH / MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3722 EDMONDSON AVE BALTO. MD. 21229																								
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Date 6-12-99		20d. Location - City or Town, State BALTO. MD																						
	21. Signature of Funeral Service Licensee Vaughn C. Greene				22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO NATL PIKE, BALTO. MD. 21229																								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																												
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>HEMORRHAGIC CVA</td> <td>24h</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>SUBARACHNOID HEMORRHAGE</td> <td>24h</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>HTN</td> <td>4 years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>SUBSTANCE ABUSE</td> <td>UNKNOWN</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	HEMORRHAGIC CVA	24h	Due to (or as a consequence of):			b.	SUBARACHNOID HEMORRHAGE	24h	Due to (or as a consequence of):			c.	HTN	4 years	Due to (or as a consequence of):			d.	SUBSTANCE ABUSE
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	HEMORRHAGIC CVA	24h																										
	Due to (or as a consequence of):																												
	b.	SUBARACHNOID HEMORRHAGE	24h																										
	Due to (or as a consequence of):																												
c.	HTN	4 years																											
Due to (or as a consequence of):																													
d.	SUBSTANCE ABUSE	UNKNOWN																											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																													
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																													
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																													
29b. Signature and title of certifier Shuler MD.				29c. License number P11701		29d. Date signed (Month, Day, Year) JUNE 7 1999																							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FLORIN NICULESCU 900 CATON AVE BALTIMORE MD 21229																													
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature Benita S. Sparks																											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99-18927

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mamie R. Ruth

2. Date of Death

06-12-99

Month

Day

Year

3. Time of Death

10:05PM

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Hamilton

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-03-2730

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03/07/1909

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3819 BelAir Road

10f. Zip Code

21213

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

8

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sales Lady

16b. Kind of Business/Industry

Clothing/Retail

17. Father's Name (First, Middle, Last)

Joseph Tuminello

18. Mother's Name (First, Middle, Maiden Surname)

Seraphina Rinavdo

19a. Informant's Name/Relationship (Type, Print)

Patricia B. McGraw/Daughter in Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8800 Walther Blvd. (Apt 4613) Baltimore, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

06/15/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Christina L. David

22. Name and Address of Facility

Leonard J. Ruck
5305 Harford Road, Baltimore, Maryland 2121423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Hypothyroidism
Parkinson's Depression
gastitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Howard H. B. M. M.D.

29c. License number

D19793

29d. Date signed (Month, Day, Year)

6/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9618 Belair Road Baltimore Md 21236

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended Item#19a perFHG772 6/18/99 EW

Reg. No. 99 18928

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ESTHER B RASKIN				2. Date of Death Month Day Year JUNE 9 1999		3. Time of Death 4:40AM		
	4a. Facility Name (If not institution, give street and number) FUTURE CARE - CHERRYWOOD				4b. City, Town, or Location of Death REISTERSTOWN		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 213-34-2922		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) NOV 15, 1904		
	9. Birthplace (State or Foreign Country) RUSSIA		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location REISTERSTOWN		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 12020 REISTERSTOWN RD.		10f. Zip Code 21136		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES		16b. Kind of Business/Industry RETAIL					
17. Father's Name (First, Middle, Last) HYMAN BASS				18. Mother's Name (First, Middle, Maiden Surname) JENNIE TONEY					
19a. Informant's Name/Relationship (Type, Print) MRS. ANITA FRIEDMAN (DAUG.) Friedmann				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8819 GROFFS MILL DR. OWINGS MILLS, MD 21117					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LIBERTY PARK (SHAAREI ZION)		20c. Date 6/11/99		20d. Location - City or Town, State RANDALLSTOWN, MD			
21. Signature of Funeral Service Licensee <i>Scott M. Gottlieb</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dementia - Alzheimer's type Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 6 yrs	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal insufficiency Artrial fibrillation								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Jude Blue</i>		29c. License number D27123		29d. Date signed (Month, Day, Year) 6/9/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude Minkone 750 Main St Reisterstown, MD 21136									
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature <i>James B. Sparks</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18929

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RABUS H. ROLLINS					2. Date of Death Month JUNE Day 12 Year 1999		3. Time of Death 8:15 AM		
	4a. Facility Name (If not institution, give street and number) Church Home					4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 216-05-3699		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) April 4, 1903		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 101 N. Bond St.				10f. Zip Code 21231		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) projector operator				16b. Kind of Business/Industry cinema		
	17. Father's Name (First, Middle, Last) Clarence Linwood Rollins					18. Mother's Name (First, Middle, Maiden Surname) Lillian Deshieds Hicks				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Barry Rollins/nephew					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Sussex Rd. Towson, MD 21286				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 6/19/99		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee John O. Mitchell II					22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212				
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): YEARS									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Due to (or as a consequence of):									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CANCER OF PROSTATE							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier A. R. Nazemi MD		29c. License number 017322		29d. Date signed (Month, Day, Year) JUNE 12, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. R. NAZEMI, M.D. CHURCH HOSPITAL, BALTIMORE, MD 21231										
State Registrar	31. Date filed (Month, Day, Year) JUN 14 1999					32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10 AH

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18930

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT E. SCOTT				2. Date of Death Month Day Year June 08, 1999		3. Time of Death 10:11 A.M.		
	4a. Facility Name (If not institution, give street and number) 3600 W. Belvedere Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-40-1313	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEBRUARY 14, 1942		9. Birthplace (State or Foreign Country)	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County NA	10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 Yes 2 No			
	10e. Street and Number 3600 BELVEDERE AVE			10f. Zip Code 21215		10g. Citizen of What Country? USA			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1960-1965		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant Seaman		16b. Kind of Business/Industry SHIPPING				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) BERNARD SCOTT			18. Mother's Name (First, Middle, Maiden Surname) DOROTHY PERKINS					
	19a. Informant's Name/Relationship (Type, Print) Sophia Scott (exwife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4102 Newbern Ave #15 BALTO. MD 21215					
	20a. Method of Disposition 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		Date 6-11-99		20c. Location - City or Town, State CATONSVILLE, MD		
	21. Signature of Funeral Service Licensee [Signature]			22. Name and Address of Facility Robert E. Nylus F/H PA 638 N. Gilmer St BALTIMORE, MD 21217					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? Inspection 1 Yes 2 <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
State Registrar	29b. Signature and title of certifier Theodore M. King			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 09, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201								
State Registrar	31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#24a per Verbal MD G772 6/14/99 EW
AMENDED ITEM#26 PER M.D. G772 6/9/99 AH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18931

SCHILLER, EVERETT

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

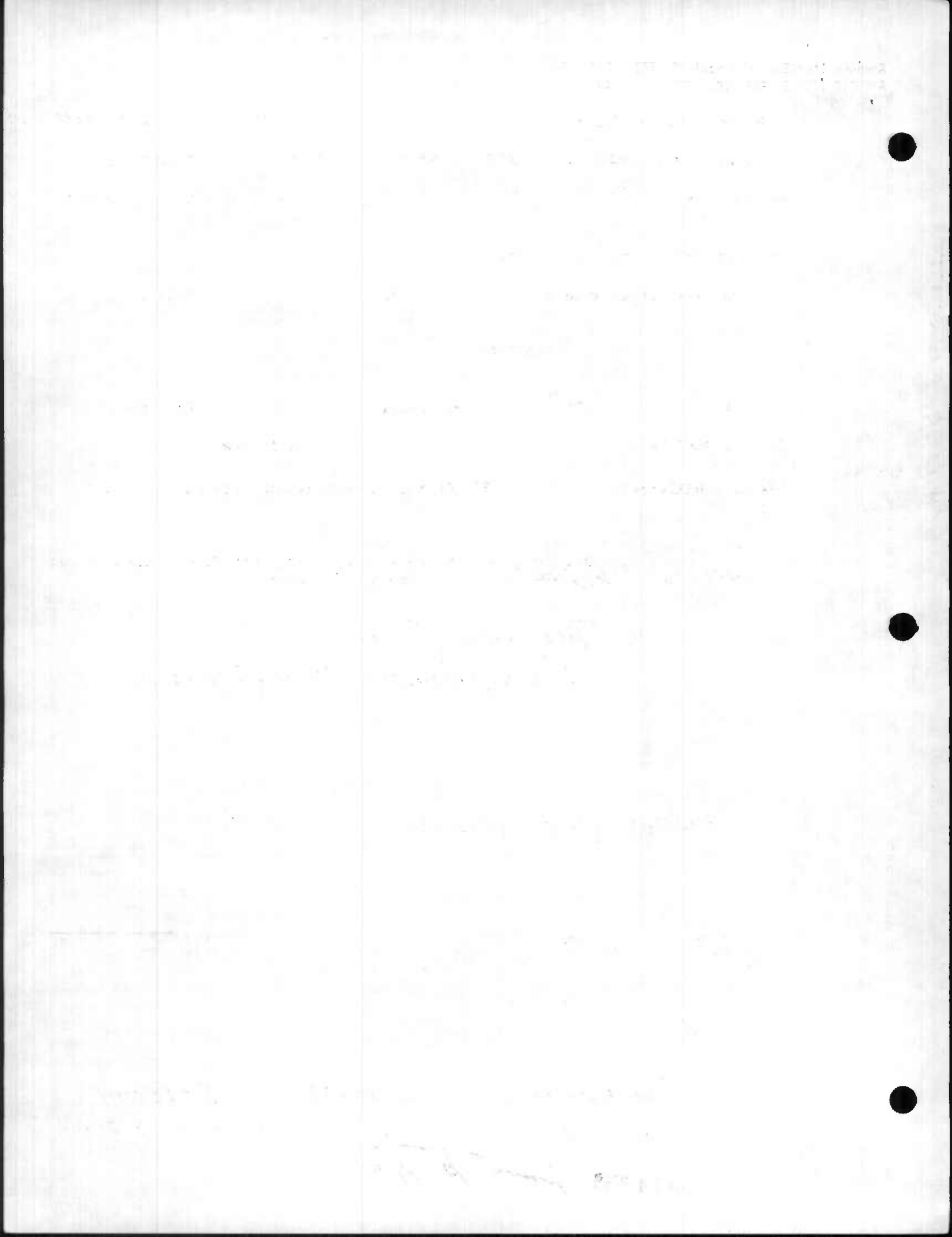
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Everett L. Schiller				2. Date of Death Month MAY Day 17 Year 1999		3. Time of Death 3:40 P.M.	
4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
5. Social Security Number 397-07-3595		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 31, 1917	
9. Birthplace (State or Foreign Country) Wisconsin							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 517 Charles Street Avenue				10f. Zip Code 21204		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor		16b. Kind of Business/Industry Education	
17. Father's Name (First, Middle, Last) Gust H. Schiller				18. Mother's Name (First, Middle, Maiden Surname) Ethel Stringham			
19a. Informant's Name/Relationship (Type, Print) Iva L. Schiller/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 Charles Street Avenue, Towson, MD 21204			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee  Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Respiratory Failure. Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24c. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery disease							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) FEU					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier  M. Schwartz				29c. License number D-44728		29d. Date signed (Month, Day, Year) 5-18-99	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MITCHELL SCHWARTZ 6569 N. CHARLES ST BALTIMORE, MD 21204							
31. Date filed (Month, Day, Year) JUN 14 1999				32. Registrar's Signature  J. B. Sparks			



99 18932

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMENDED ITEM #1 PER MD G774 8/11/99 AH

99 18933

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna E.D Shankle				2. Date of Death Month May Day 23 Year 1999		3. Time of Death 5:45 A.M.	
	4a. Facility Name (If not institution, give street and number) Manor Care - Wheaton				4b. City, Town, or Location of Death Wheaton		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-05-1418		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 16, 1914	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State		10b. County		10c. City, Town or Location Washington, D. C.			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 4504 30th Street N.W.				10f. Zip Code 20016		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Keeper			16b. Kind of Business/Industry Television Station	
17. Father's Name (First, Middle, Last) Raymond Sweeney					18. Mother's Name (First, Middle, Maiden Surname) Alice E. Rogers			
19a. Informant's Name/Relationship (Type, Print) Nola Telfer - Friend					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1702 Glen Karney Place Silver Spring, MD 20902			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		Date 5/24/99	20c. Location - City or Town, State Frederick, MD		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D. C. 20016			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Colon Cancer a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 					29c. License number D 42578		29d. Date signed (Month, Day, Year) May 24, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani, M. D. 11119 Rockville Pike #316 Rockville, Maryland 20852								
31. Date filed (Month, Day, Year) JUN 14 1999			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

10 A4

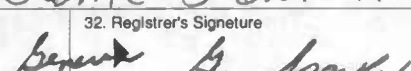
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18934

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BETTY SUSMAN		2. Date of Death Month Day Year JUNE 8, 1999		3. Time of Death 9:37 PM
	4e. Facility Name (If not institution, give street and number) GILCHRIST CENTER HOSPICE OF BALTIMORE		4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 215-09-4428	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) JUNE 26, 1913		9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent					
10e. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10e. Street and Number 2904 TERRY DRIVE #D		10f. Zip Code 21209		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK		16b. Kind of Business/Industry SUPERIOR COURT	
17. Father's Name (First, Middle, Last) ABRAHAM COHEN		18. Mother's Name (First, Middle, Maiden Surname) JENNY DAVIDOV			
19a. Informant's Name/Relationship (Type, Print) FLORA COHEN / SISTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7121 PARK HEIGHTS AVE. #603 - BALTIMORE, MD 21215			
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LUBAWITZ NUSACH ARI CEM.		20c. Location - City or Town, State ROSEDALE, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Colon cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 3 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D25205		29d. Date signed (Month, Day, Year) June 9, 1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W.A. Riley GMC 6701 N. Charles St. Balto. md 21208					
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18935

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RAE SCHWARTZ		2. Date of Death Month JUNE Day 10 Year 1999		3. Time of Death 12:05 PM
	4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 213-44-9449	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) MAY 4, 1913		9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent					
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 34 STIRRUP COURT			10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry OWN HOME	
17. Father's Name (First, Middle, Last) NATHAN WOLFF		18. Mother's Name (First, Middle, Maiden Surname) GUSSIE TURNER			
19a. Informant's Name/Relationship (Type, Print) MAYTA TUCKER / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 STIRRUP COURT - BALTIMORE, MD 21208			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH YEHUDA ANSHE KURLAND		20c. Location - City or Town, State 6/11/99 BALTIMORE, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death 48°
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinsons disease					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  LOUIS MALINOW MD		29c. License number D 51896		29d. Date signed (Month, Day, Year) 6/10/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOUIS MALINOW 3635 OLD COURT RD BALTIMORE MD 21208					
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18936

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID TALLEY				2. Date of Death Month 6 Day 13 Year 99		3. Time of Death 5:45pm	
	4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 215-24-5449		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3-28-30	9. Birthplace (State or Foreign Country) VA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 4114 Normandy Ave				10f. Zip Code 21229		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman			16b. Kind of Business/Industry Steel mill		
	17. Father's Name (First, Middle, Last) Benjamin Talley				18. Mother's Name (First, Middle, Maiden Surname) Mamie Richardson			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Yvonne Talley / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4114 Normandy Ave Balto, MD 21229			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Cemetery		Date 6-18-99		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Vaughn C. L.				22. Name and Address of Facility Vaughn C. Greene Funeral Services 5151 B. Lto Nett Plce Balto MD 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. respiratory Failure b. Sepsis c. End Stage renal Disease d. Intestinal obstruction							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Vaughn R. Cruz M.D.		29c. License number 00030355		29d. Date signed (Month, Day, Year) 6/13/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSITA R. CRUZ M.D. BON SECOURS HOSPITAL								
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

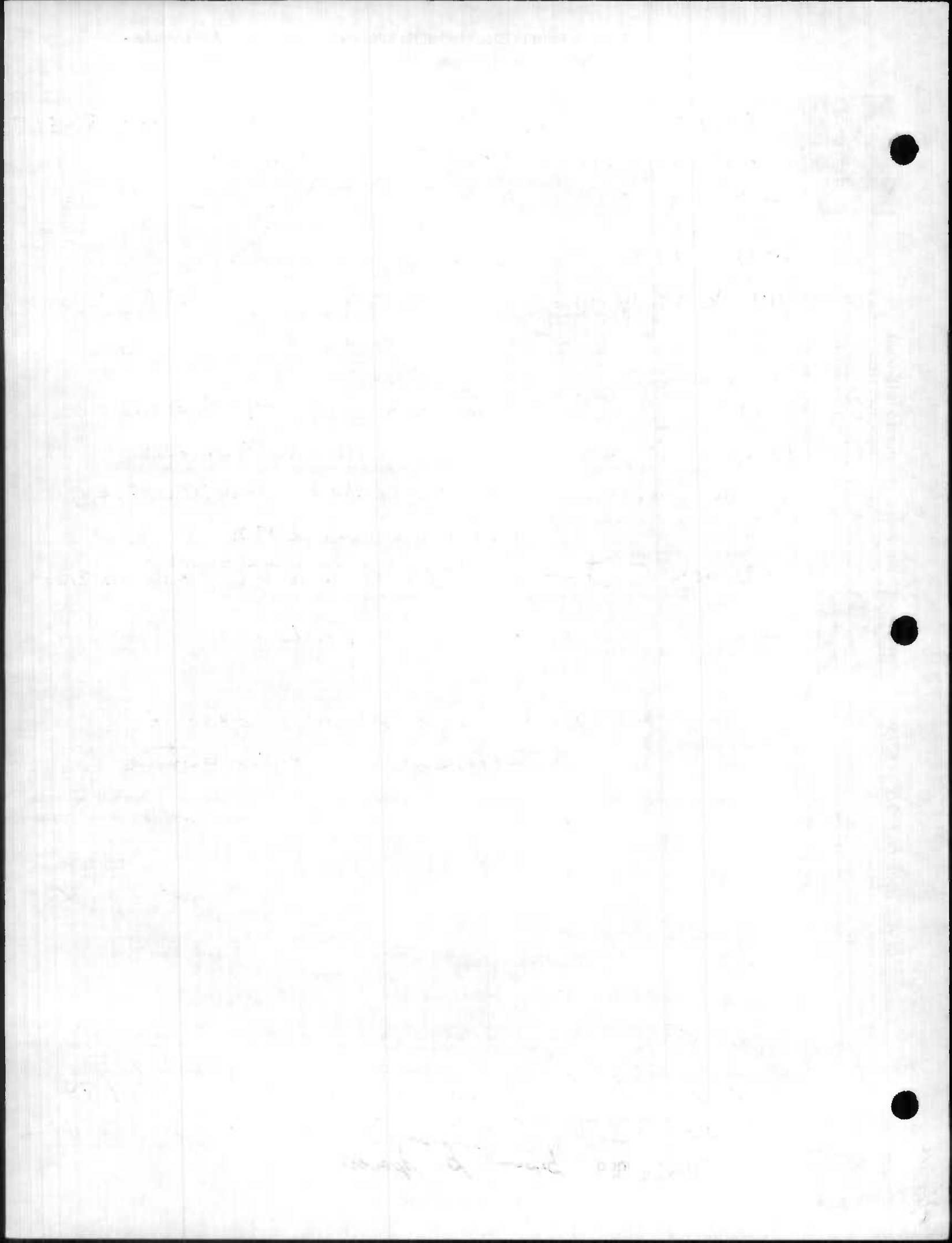
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18937

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eleanora Tate				2. Date of Death Month Day Year June 11, 1999				3. Time of Death 3:45 am					
	4a. Facility Name (If not institution, give street and number) Future Care Old Court Nursing Home				4b. City, Town, or Location of Death Randallstown				4c. County of Death Baltimore					
Funeral Director	5. Social Security Number 198-28-0641		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Aug 31, 1903		9. Birthplace (State or Foreign Country) PA	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Randallstown				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 5412 Old Court Road				10f. Zip Code 21133				10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home					
	17. Father's Name (First, Middle, Last) Florian Altmann				18. Mother's Name (First, Middle, Maiden Summa) Margatha Hirshline									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) William J. Tate, Jr. / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 948 C Lorimer Road, Eldersburg Maryland 21784									
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Joseph Cemetery, June 14, 1999				20c. Location - City or Town, State Easton, PA					
	21. Signature of Funeral Service Licensee Victor P. Doda, Jr.				22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PROBABLE MYOCARDIAL INFARCTION = 5 min Due to (or as a consequence of): b. CHRONIC RENAL FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE													
State Registrar	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred					
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
State Registrar	29b. Signature and title of certifier M. Doda ATTENDING				29c. License number 740390				29d. Date signed (Month, Day, Year) JUNE 11, 1999					
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) A. R. D. ELAL, MD; 5310 OLD COURT RD, #201, RANDALLSTOWN, MD 21133													
State Registrar	31. Date filed (Month, Day, Year) JUN 14 1999				32. Registrar's Signature B. Sparks									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18938

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Thomas				2. Date of Death Month Day Year June 9, 1999				3. Time of Death 6:15 am							
	4a. Facility Name (If not institution, give street and number) 2220 Benson Mill Road				4b. City, Town, or Location of Death Sparks, MD				4c. County of Death Baltimore							
Funeral Director	5. Social Security Number 426-07-8591		6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 10, 1910		9. Birthplace (State or Foreign Country) MS							
	Usual Residence of Decedent															
10a. State MD		10b. County Baltimore		10c. City, Town or Location Sparks Maryland				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
10e. Street and Number 2220 Benson Mill Road				10f. Zip Code 21152				10g. Citizen of What Country? United States								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary / Bookkeeper				16b. Kind of Business/Industry Food								
17. Father's Name (First, Middle, Last) Claude Lee Travis				18. Mother's Name (First, Middle, Maiden Surname) Myrtis Elizabeth Lane												
19a. Informant's Name/Relationship (Type, Print) Beth Varner / Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2220 Benson Mill Road, Sparks MD 21152												
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lakewood Mem. Park, June 14, 1999			20c. Location - City or Town, State Jackson, MS										
21. Signature of Funeral Service Licensee Victor P. Doda, Jr.				22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td rowspan="4"> { </td> <td>a. congestive heart failure and pulmonary hypertension</td> <td rowspan="4"> Approximate Interval Between Onset and Death 34 mo. 243 </td> </tr> <tr> <td>b. metastatic leiomyosarcoma</td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	a. congestive heart failure and pulmonary hypertension	Approximate Interval Between Onset and Death 34 mo. 243	b. metastatic leiomyosarcoma	c.	d.
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	a. congestive heart failure and pulmonary hypertension	Approximate Interval Between Onset and Death 34 mo. 243													
		b. metastatic leiomyosarcoma														
		c.														
		d.														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. coronary artery disease / multi infarct dementia / cerebrovascular disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred								
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier Ruth Kanter MD				29c. License number D28594		29d. Date signed (Month, Day, Year) 6/9/99										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruth Kanter, MD 6701 North Charles Street, Baltimore Maryland 21204																
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature B. Sparks														

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended Item#26 perPhyG772 6/14/99 EW

Reg. No. 99 18939

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) <i>Thelma Taylor</i>				2. Date of Death Month Day Year <i>APRIL 10, 1999</i>		3. Time of Death <i>4:35 AM</i>	
4a. Facility Name (If not institution, give street and number) <i>Gladys Spellman Nursing Home</i>				4b. City, Town, or Location of Death <i>Chesley Rd. Prince George</i>		4c. County of Death <i>Prince George</i>	
5. Social Security Number <i>125-16-9218</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>90</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min	8. Date of Birth (Month, Day, Year) <i>April 3, 1909</i>	9. Birthplace (State or Foreign Country) <i>South Carolina</i>

Usual Residence of Decedent		10a. State <i>Pa.</i>		10b. County <i>Phila.</i>		10c. City, Town or Location <i>Phila.</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
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10e. Street and Number <i>6220 Gontz Ave.</i>		10f. Zip Code <i>Phila. Pa. 19141</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
--	--	--	--	--	--

11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Cook</i>		16b. Kind of Business/Industry <i>Board of Education</i>	
---	--	--	--	---	--

17. Father's Name (First, Middle, Last) <i>Abraham Howell</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Emma Unt.</i>	
--	--	---	--

19a. Informant's Name/Relationship (Type, Print) <i>Christine Guyton daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6220 Gontz Ave. Phila. Pa. 19141</i>	
--	--	--	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Lawn Cemetery</i>		20c. Location - City or Town, State <i>Sharon Hill, Pa.</i>	
---	--	--	--	--	--

21. Signature of Funeral Service Licensee <i>Carlton C. Douglas</i>		22. Name and Address of Facility <i>Douglas Funeral Service 1701 McCulloh St.</i>	
--	--	--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. arrhythmia</i> Due to (or as a consequence of): <i>b. resp failure s/p trach</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i>		Approximate Interval Between Onset and Death <i>seconds</i> <i>weeks</i>	
--	--	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
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29b. Signature and title of certifier <i>Meera Kanhouwa</i>		29c. License number <i>D52222</i>		29d. Date signed (Month, Day, Year) <i>APRIL 10, 1999</i>	
--	--	--------------------------------------	--	--	--

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Meera KANHOUWA, Gladys Spellman Nursing Home</i>	
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31. Date filed (Month, Day, Year) <i>JUN 14 1999</i>		32. Registrar's Signature <i>B. Sparks</i>	
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

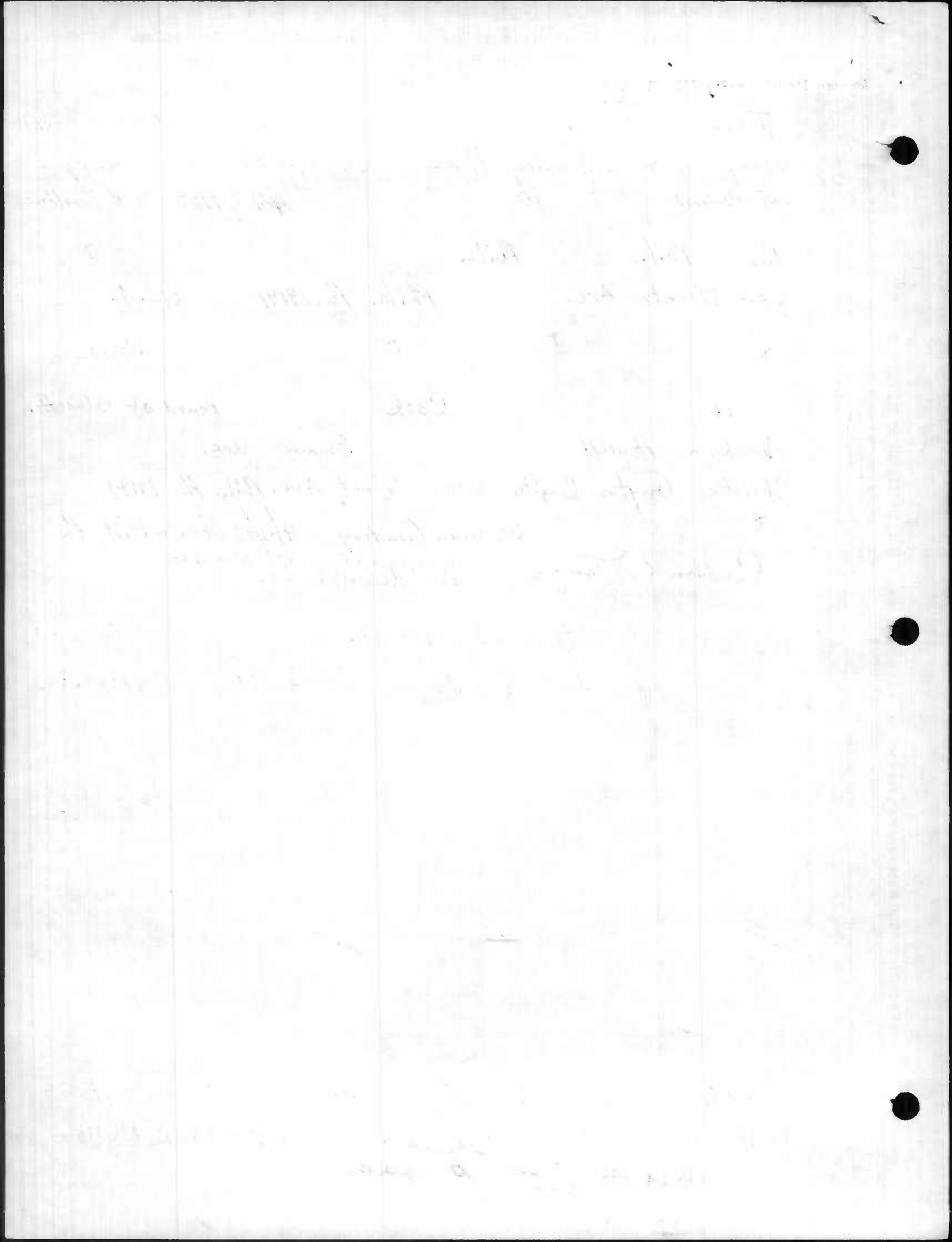
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

Amend Item #5, per FH, G772, 6/29/99, gap

Certificate of Death

99 18940

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY Cornelia Wyche

2. Date of Death

Month Day Year

June 11 1999

3. Time of Death

9:55 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MARINER Health Place

4b. City, Town, or Location of Death

BELAIR

4c. County of Death

HARFORD Co.

5. Social Security 215-32-9374 Sex

224 16 5935 1 M 2 F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 4, 1932

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Maryland

10b. County

HARFORD

10c. City, Town or Location

BELAIR

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

124 Archer Street

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

PRIVATE Family

17. Father's Name (First, Middle, Last)

WALLACE Govans

18. Mother's Name (First, Middle, Maiden Surname)

Laura Rebecca Blaney

19a. Informant's Name/Relationship (Type, Print)

Pinkie Wyche

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 Archer St. BELAIR Md 21014

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chestnut Grove Chcem

Date

6/15

20c. Location - City or Town, State

Street Md.

21. Signature of Funeral Service Licensee

Blow Adams Jones

22. Name and Address of Facility

MARSHALL W JONES, JR. F&PA
4101 Edmondson Ave. Balt. Md 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Colon Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician

2 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alfred L. C. Sun, M.D.

29c. License number

D-18779

29d. Date signed (Month, Day, Year)

June 11, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1800 Harford Road, Fallston, MD 21047

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

J. B. Sparks

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10-10-77

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10-10-77

99-3316-510
cm
Francine Wells

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18941

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francine Wells

2. Date of Death
Month Day Year
June 08, 1999

3. Time of Death
11:20 A.M.

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number
214-84-9408

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
36 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
03-01-63

9. Birthplace (State or Foreign
Country)
MD

Usual Residence of Decedent

10a. State
MD

10b. County
NA

10c. City, Town or Location
Baltimore

10d. Inside City Limits
☒ Yes ☐ No

10e. Street and Number

1905 E. 30th Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.
Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th Grade

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Worker

16b. Kind of Business/Industry

Factory worker

17. Father's Name (First, Middle, Last)

Frank O. Wells

18. Mother's Name (First, Middle, Maiden Surname)

Annie R. McMillian

19a. Informant's Name/Relationship (Type, Print)

Annie R. Wells

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

143 Worth Street St. Paul, NC 28384

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arbutus Mem. Pk. Cem.

Date

06-12-99

20c. Location - City or Town, State

Arbutus, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final
disease or condition
resulting in death)

Complications from Cocaine & Narcotic Intoxication

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy
performed?

Approval

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☒ Could not be determined

28a. Date of Injury
(Month, Day, Year)

06-03-1999

28b. Time of
Injury

Unknown

28c. Injury at
Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Unknown

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Unknown

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

Unknown

29a. Certifier
(Check only
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25055

29d. Date signed (Month, Day, Year)

June 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT J. WILLIAMS

5602 Baltimore National Pike, Balto., MD 21228

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-7 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18942

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Agnes Madeline Wisner				2. Date of Death Month Day Year JUNE 9, 1999		3. Time of Death 5:30 AM		
	4a. Facility Name (If not Institution, give street and number) 6395 Euclid Avenue				4b. City, Town, or Location of Death Elkridge		4c. County of Death Howard		
Funeral Director	5. Social Security Number 218-10-0255		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) MAR 29, 1917		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Howard		10c. City, Town or Location Elkridge		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6395 Euclid Avenue		10f. Zip Code 21075		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Line Worker		16b. Kind of Business/Industry Factory		17. Father's Name (First, Middle, Last) William Henry Coolahan		18. Mother's Name (First, Middle, Maiden Surname) Blanche Estelle Grummlin	
19a. Informant's Name/Relationship (Type, Print) Milton S. Wisner, Jr. - husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6395 Euclid Avenue, Elkridge, Md. 21075		20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Pk.		20c. Location - City or Town, State Elkridge, Md.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gary L. Kaufman Funeral Home@Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ACUTE RENAL FAILURE</u> Due to (or as a consequence of): b. <u>CHRONIC RENAL FAILURE</u> Due to (or as a consequence of): c. <u>HYPERTENSION</u> Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death TWO WEEKS. MONTHS. YEARS.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) June 9, 1999		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 30469.		29d. Date signed (Month, Day, Year) June 10th, 1999.			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.B. Vellanki, 9055, Chevrolet Drive, #100, Ellicott City, MD 21042.		31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

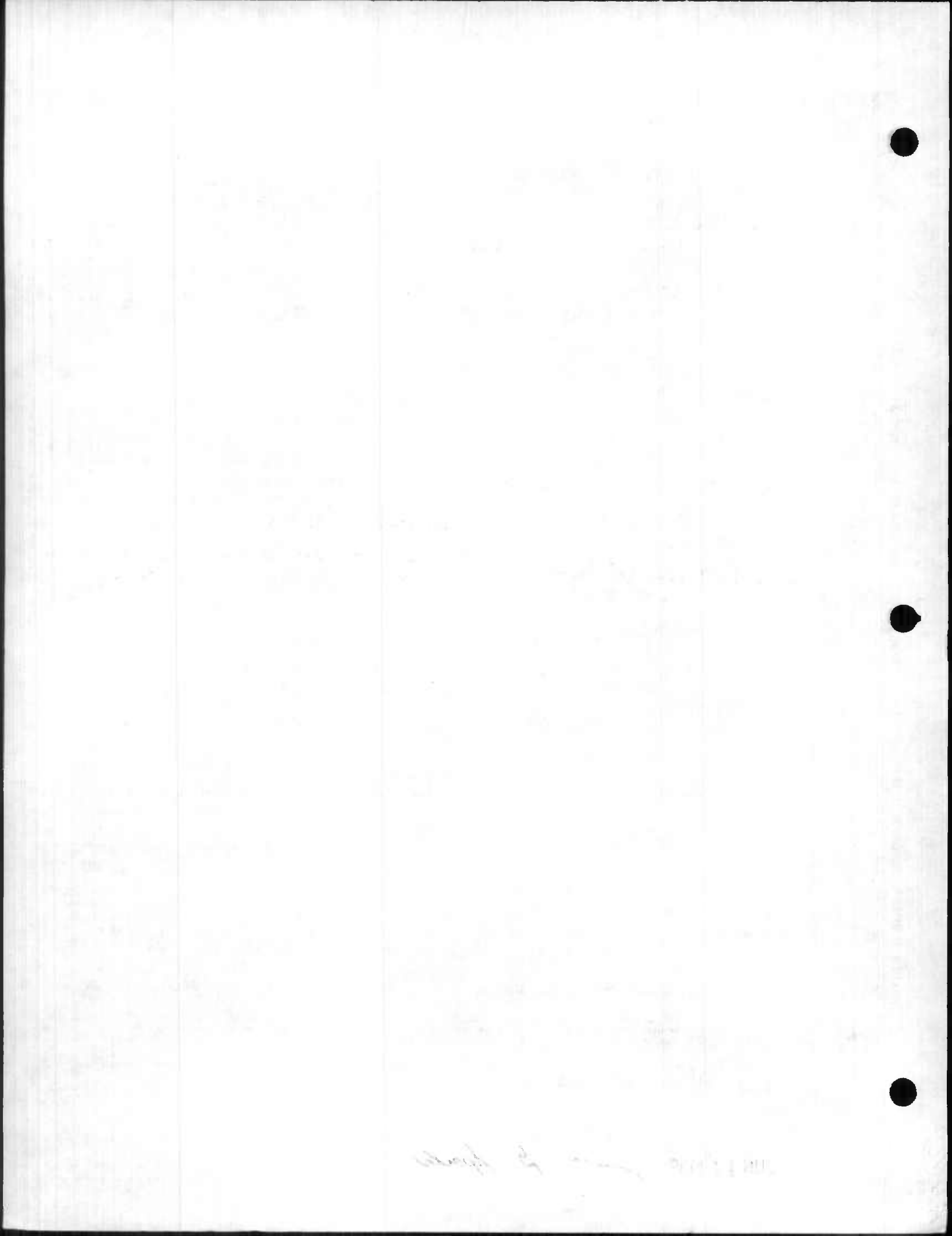
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18943

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Noble G. Williams				2. Date of Death Month 6 Day 9 Year 1999		3. Time of Death 8:30 A.M.		
	4a. Facility Name (If not institution, give street and number) Rock Glen N/H				4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director	5. Social Security Number 213-09-2634		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 4-13-1913		
	9. Birthplace (State or Foreign Country) Va		10a. State Md		10b. County Baltimore		10c. City, Town or Location Catonsville		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 313 Winters Lane		10f. Zip Code 21228		10g. Citizen of What Country? U S A	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th grade		College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Bethlehem Steel			
17. Father's Name (First, Middle, Last) Eddie Williams				18. Mother's Name (First, Middle, Maiden Surname) Mattie Dotson					
19a. Informant's Name/Relationship (Type, Print) Mavis Williams - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Winters Lane Catonsville, Md 21228					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park		Date 6-17-99		20c. Location - City or Town, State Arbutus, Md			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Metastatic cancer Due to (or as a consequence of): b. Carcinoma of colon Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 3 mo 1 yr					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 21649		29d. Date signed (Month, Day, Year) June 10, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMBANDAN SASKARAN 3455 Wilkens Av. Baltimore MD 21229		31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #20b PER FH G772 6/14/99 AH

Certificate of Death

Reg. No.

99 18944

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sylvia Welch				2. Date of Death Month Day Year June 11 1999		3. Time of Death 2:20am	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-26-1092	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	8. Date of Birth (Month, Day, Year) Jan 16, 1930	9. Birthplace (State or Foreign Country) Baltimore			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 1238 Sherwood Avenue		10f. Zip Code 21239		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Counselor		16b. Kind of Business/Industry Education			
	17. Father's Name (First, Middle, Last) George Johnson				18. Mother's Name (First, Middle, Maiden Surname) Emma Sheffey			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Michael W. Cole - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1238 Sherwood Ave Baltimore MD-21239			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of GREEN MOUNT cemetery, crematory or other place) 1238 Sherwood Ave		20c. Location - City or Town, State Baltimore, MD		20d. Date June 13, 1999	
	21. Signature of Funeral Service Licensee Carlton C. Douglas				22. Name and Address of Facility Daglass Funeral Service 1701 McCulloh Street, Baltimore, Maryland 21217			
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Multisystem Organ Failure				Approximate Interval Between Onset and Death 2 days			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Sepsis c. Large Sacral Decubitus Ulcer d. Left gangrenous above knee amputation				11 days weeks months			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Diabetes Mellitus, Duodenal and Esophageal Ulcers, Atrial Fibrillation						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Michelle Aprado, MD				29c. License number AU4176435A9155		29d. Date signed (Month, Day, Year) June 11, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle L. Aprado, MD Union Memorial Hospital Baltimore MD								
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18945

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James H. Waters Jr.				2. Date of Death Month JUNE Day 08 , Year 1999		3. Time of Death 5:47 PM.	
	4a. Facility Name (If not institution, give street and number) 1531 POPLAR GROVE ST.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NIA	
Funeral Director	5. Social Security Number 213-78-6247		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) July 27, 1960	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County NIA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1531 Poplar Grove St.		10f. Zip Code 21216		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Grocery				
17. Father's Name (First, Middle, Last) James H. Waters Sr.				18. Mother's Name (First, Middle, Maiden Surname) Flora Smith				
19a. Informant's Name/Relationship (Type, Print) Flora Smith				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 Poplar Grove St. Balto, MD. 21216				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 16-15-99 Lansdowne, MD				
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Gary P. March Funeral Home P.A. 2707 Redbitten Pass Balto., MD. 21229						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bronchopneumonia complicating Diabetes Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 09, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRISON KOREN 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended Item#24a,25 per PhyG772 6/14/99 EW

Reg. No. 99 18916

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Diane L. Waite-Case						2. Date of Death Month Day Year MAY 22 1999		3. Time of Death 6:20 PM		
	4a. Facility Name (If not institution, give street and number) 720 N. Carrollton Avenue						4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director	5. Social Security Number 165-40-2984		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 9, 1952		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 720 N. Carrollton Avenue				10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator				16b. Kind of Business/Industry Public School				
	17. Father's Name (First, Middle, Last) William Herin Waite						18. Mother's Name (First, Middle, Maiden Surname) Beatrice Nowell Anderson				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) John Gregory Case/spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 N. Carrollton Avenue, Baltimore, MD 21217						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State				
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Liver failure Due to (or as a consequence of): b. Metastatic Breast Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d.										2 weeks 9 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Charles Padgett, MD						29c. License number D15546		29d. Date signed (Month, Day, Year) May 24, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Padgett, MD, 5601 Loch Raven Blvd, Baltimore, MD 21239											
31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature James B. Sparks									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

99 18947

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Chang Bong Yi

2. Date of Death

JUNE

Day TEN Year 1999

3. Time of Death

5:25 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

237-27-7584

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR 9, 1917

9. Birthplace (State or Foreign Country)

Korea

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11 West 20th Street, Apt. 5-I

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Assist.

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Hui Si Yi

18. Mother's Name (First, Middle, Maiden Surname)

Sook J. Kim

19a. Informant's Name/Relationship (Type, Print)

Sylvia Yi - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

40 West Laurel St., Apopka, FL 32703

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Memorial Park

Date

6/13/99

20c. Location - City or Town, State

Orlando, Florida

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge, MP, Inc.
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BILATERAL PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

MALNUTRITION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

06/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SONAL SETHI, MD
UNION MEMORIAL HOSPITAL, 201 EAST UNIVERSITY PARKWAY, BALTIMORE MD

31. Date filed (Month, Day, Year)

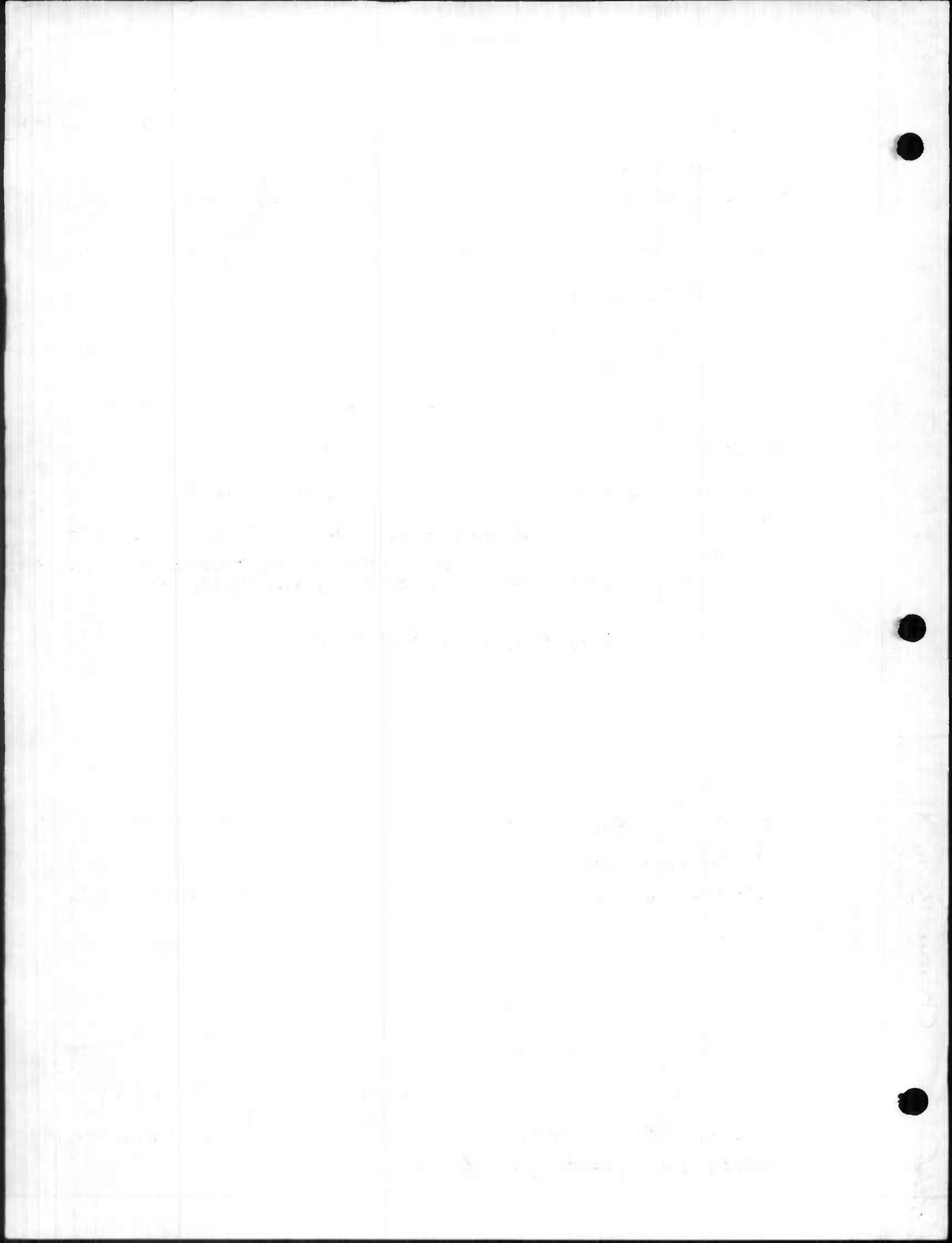
JUN 14 1999

32. Registrar's Signature


State
RegistrarPhysician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18948

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Aycock

2. Date of Death

Month Day Year
5 29 99

3. Time of Death

6:30am

4a. Facility Name (If not institution, give street and number)

COPPER RIDGE

4b. City, Town, or Location of Death

SYKESVILLE

4c. County of Death

CARROLL

Funeral
Director

5. Social Security Number

212-10-0885

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 17, 1908

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

710 Obrecht Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Engineering

17. Father's Name (First, Middle, Last)

Joseph Aycock

18. Mother's Name (First, Middle, Maiden Surname)

Rachael R. Boone

19a. Informant's Name/Relationship (Type, Print) (grand-
son)

David K. Johnstone III

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1690 Calico Dr., Woodbine, Md. 21797

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Conestoga Mem. Park

Date

6/1/99

20c. Location - City or Town, State

Lancaster, PA

21. Signature of Funeral Service Licensee

Brian A. Hight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)
Sykesville, MD 21784 (410)-795-140023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Alzheimer's Dementia

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Ernestine Wright

29c. License number

D52740

29d. Date signed (Month, Day, Year)

5/29/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ERNESTINE WRIGHT, COPPER RIDGE, 710 OBRECHT ROAD, SYKESVILLE 21784

State
Registrar

31. Date filed (Month, Day, Year)

JUN 02 1999

32. Registrar's Signature

Benita B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

99 18949

DMMH 16 Rev 6/95

0.25" x 0.125"

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18950

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Virginia Mae Blake</u>				2. Date of Death Month <u>MAY</u> Day <u>29th</u> Year <u>1999</u>		3. Time of Death <u>0552</u>		
	4a. Facility Name (If not institution, give street and number) <u>Carroll Co Gen. Hospital</u>				4b. City, Town, or Location of Death <u>Westminster</u>		4c. County of Death <u>Carroll</u>		
Funeral Director	5. Social Security Number <u>232-48-4438</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs./last birthday) <u>70</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Apr 8 1929</u>		
	10a. State <u>MD</u>		10b. County <u>Carroll</u>		10c. City, Town or Location <u>Westminster</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <u>407 John Owings Road</u>				10f. Zip Code <u>21158</u>		10g. Citizen of What Country? <u>USA</u>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (14 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>		16b. Kind of Business/Industry <u>Own Home</u>			
17. Father's Name (First, Middle, Last) <u>John Meddings</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Frona Cornell</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Peggy Faulk/daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Rt. 6 Jay, Florida 32565</u>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Whittfield Cemetery</u>		20c. Date <u>6/3/99</u>		20d. Location - City or Town, State <u>Milton, Florida</u>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>Pritts Funeral Home & Chapel</u> <u>412 Washington Road Westminster, MD 21157</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>PNEUMONIA</u> Due to (or as a consequence of): b. <u>CEREBROVASCULAR ACCIDENT</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>UROSEPSIS</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <u>D51596</u>		29d. Date signed (Month, Day, Year) <u>MAY 29th 1999</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>K. AMBALAVANAD, CARROLL COUNTY GENERAL HOSPITAL, 200 MEMORIAL AVE, WESTMINSTER</u>									
31. Date filed (Month, Day, Year) <u>JUN 01 1999</u>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

9913904646 UNIT # 12-18-83

BLAKE, VIRGINIA MAE

ICU-A RICKETTS, ROBERT M

04/08/1929 F

INP 05/20/99



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18951

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard Collick				2. Date of Death Month May Day 20 , Year 1999		3. Time of Death 4AM		
	4a. Facility Name (If not institution, give street and number) Salisbury Center; Genesis ElderCare				4b. City, Town, or Location of Death Salisbury, Md.		4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 214-16-4793	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8-17-19		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Wicomico	10c. City, Town or Location Salisbury			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 419 Robinson Street			10f. Zip Code 21801		10g. Citizen of What Country? U.S.A			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian			16b. Kind of Business/Industry Lumber Co.			
	17. Father's Name (First, Middle, Last) William Collick				18. Mother's Name (First, Middle, Maiden Surname) EVA mills				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Bernice Collick (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Robinson Street Salisbury Md. 21801				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. James Cemetery		20c. Location - City or Town, State 5-29-99 Snow Hill, Md.		20d. Date		
	21. Signature of Funeral Service Licensee John A. Prince				22. Name and Address of Facility Bernice Smith Funeral Home P.O. Box 331 Pocomoke City, Md. 21851				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D-39813		29d. Date signed (Month, Day, Year) 5/20/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew M. 1104 HEALTHWAY DRIVE, SALISBURY, MD 21804									
31. Date filed (Month, Day, Year) JUN 01 1999		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18952

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Agnes Chloe Francis				2. Date of Death Month May Day 31 Year 1999				3. Time of Death 0603	
4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll	
5. Social Security Number 214-20-9827		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 17, 1918		9. Birthplace (State or Foreign Country) Tennessee	
Usual Residence of Decedent									
10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2458 Manchester Road				10f. Zip Code 21102		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) William Mooney					18. Mother's Name (First, Middle, Maiden Surname) Nora Hicks				
19a. Informant's Name/Relationship (Type, Print) Angela Francis, daughter-in-law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 Melrose Dr, Rock Hill, SC 29732					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial Gard			Date 6/3		20c. Location - City or Town, State Finksburg, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cerebrovascular accident. Due to (or as a consequence of): b. HEART - BLOCK. Due to (or as a consequence of): c. CORONARY ARTERY DISEASE Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NO								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) N/A		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number 017076		29d. Date signed (Month, Day, Year) 06.01.99.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURENDRA D. MORTARIAT 3000 MANCHESTER ROAD MANCHESTER, MD. 21102.									
31. Date filed (Month, Day, Year) JUN 02 1999		32. Registrar's Signature 							

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18953

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BEATRICE ELIZABETH HAMMOND				2. Date of Death Month MAY Day 29 Year 99		3. Time of Death 9:30 AM	
	4a. Facility Name (If not institution, give street and number) 8276 PATEY WOOD ROAD				4b. City, Town, or Location of Death NEWARK		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 218-24-4458		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 6, 1928	
	9. Birthplace (State or Foreign Country) NEWARK, MD.		10a. State MD.		10b. County WORCESTER		10c. City, Town or Location NEWARK	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8276 PATEY WOOD ROAD		10f. Zip Code 21841		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry NURSING HOME			
	17. Father's Name (First, Middle, Last) CHARLES R. HAMMOND				18. Mother's Name (First, Middle, Maiden Surname) MAGGIE TINGLE			
	19a. Informant's Name/Relationship (Type, Print) JOYCE HATTON/NIECE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8276 PATEY WOOD ROAD, NEWARK, MD. 21841			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WILLIAMS AME CHURCH CEM.		Date 6-4-99		20c. Location - City or Town, State NEWARK, MD. 21841	
	21. Signature of Funeral Service Licensee <i>Loretta B. Jolley</i>				22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. <i>cardio pulmonary arrest</i> Due to (or as a consequence of): b. <i>Hypertension</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes</i>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>D. Bruce MD</i>		29c. License number D31924		29d. Date signed (Month, Day, Year) 6/2/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Douglas Bruce MD, 314 Franklin Ave, Berlin, Md								
31. Date filed (Month, Day, Year) JUN 04 1999		32. Registrar's Signature <i>Bruce B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

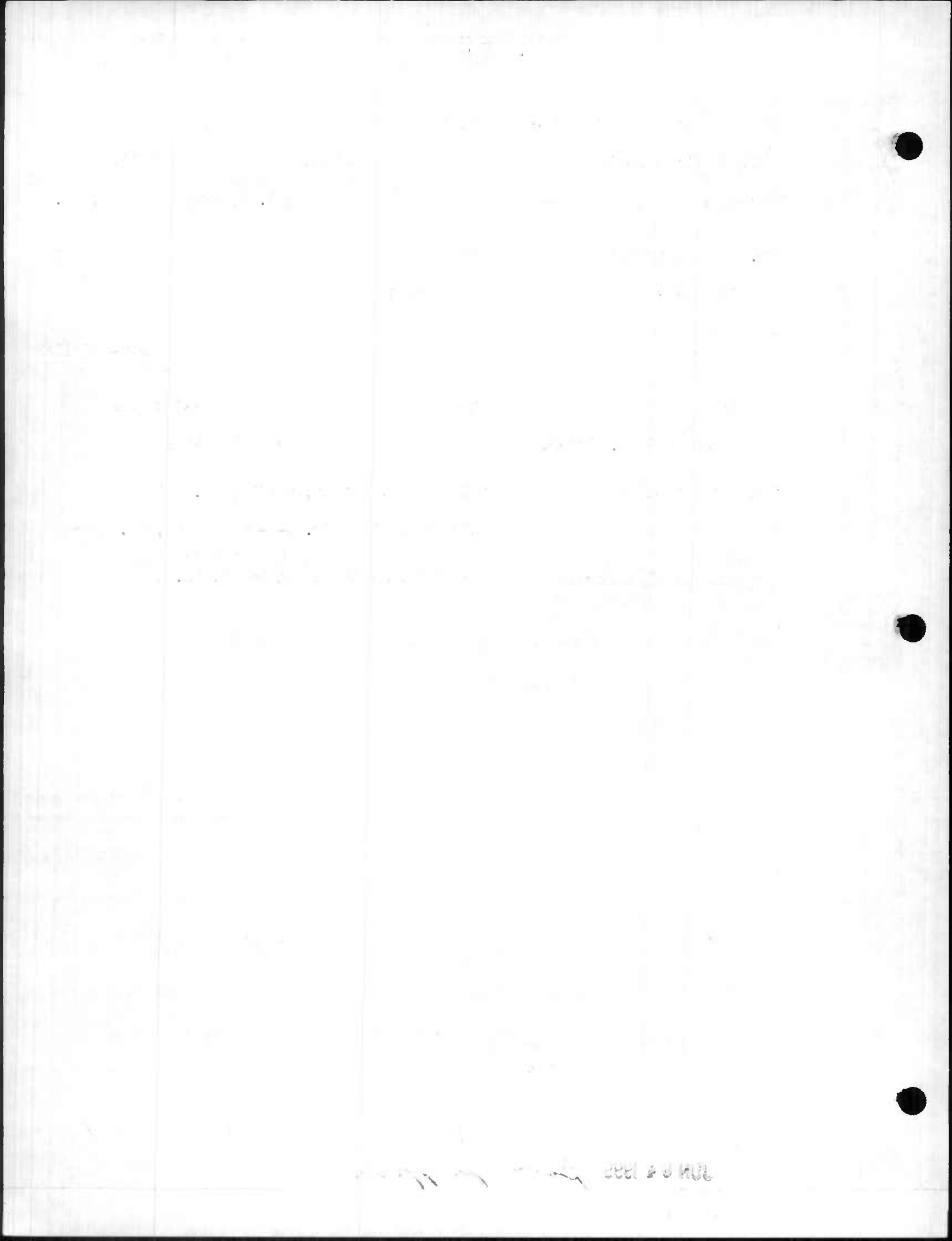
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18954

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethan Jay Hege				2. Date of Death Month Day Year May 27 '99		3. Time of Death 5:20A	
	4a. Facility Name (If not institution, give street and number) 467 Johnsville Rd.				4b. City, Town, or Location of Death Keymar		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 219-21-5417		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 13 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 5, 1986	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County Carroll		10c. City, Town or Location Keymar			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 467 Johnsville Rd.				10f. Zip Code 21757		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) Marlin Hege				18. Mother's Name (First, Middle, Maiden Surname) Martha Stickley				
19a. Informant's Name/Relationship (Type, Print) Marlin Hege/ father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 467 Johnsville Rd. Keymar, MD 21757				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Beaver Dam Cemetery		Date 5/31/99		20c. Location - City or Town, State nr. Union Bridge, MD		
21. Signature of Funeral Service Licensee Catherine O. Hartzler				22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Left Lower Lobe pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Tuberculosis Crohn's Disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier J.H. Caricote MD				29c. License number D00906		29d. Date signed (Month, Day, Year) 5/27/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J.H. Caricote MD P.O. Box 1110 Union Bridge, MD 21791								
31. Date filed (Month, Day, Year) MAY 28 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18955

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joyce Lane Hoiem				2. Date of Death Month Day Year June 6, 1999				3. Time of Death 8:20 AM	
	4a. Facility Name (If not institution, give street and number) 21606 Orwig Road				4b. City, Town, or Location of Death Freeland				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-56-1387		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Oct. 28, 1950		9. Birthplace (State or Foreign Country) Maryland		10e. State MD		10b. County Baltimore		10c. City, Town or Location Freeland	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 21606 Orwig Road		10f. Zip Code 21053		10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Manager	
	16b. Kind of Business/Industry Manufacturing		17. Father's Name (First, Middle, Last) James L. Sandridge		18. Mother's Name (First, Middle, Maiden Surname) Genevieve Sears		19a. Informant's Name/Relationship (Type, Print) Kris H. Hoiem/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21606 Orwig Rd., Freeland, MD 21053	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Yorktowne Caskets, Inc. Cremation Service		Date June 10, 1999		20c. Location - City or Town, State York, PA		21. Signature of Funeral Service Licensee <i>[Signature]</i>	
	22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. metastatic breast cancer		Approximate Interval Between Onset and Death 2 yr		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number MD 028239		29d. Date signed (Month, Day, Year) 6/7/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Harkins Oncology Center 600 N Wolfe St Baltimore MD 21287	
	31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

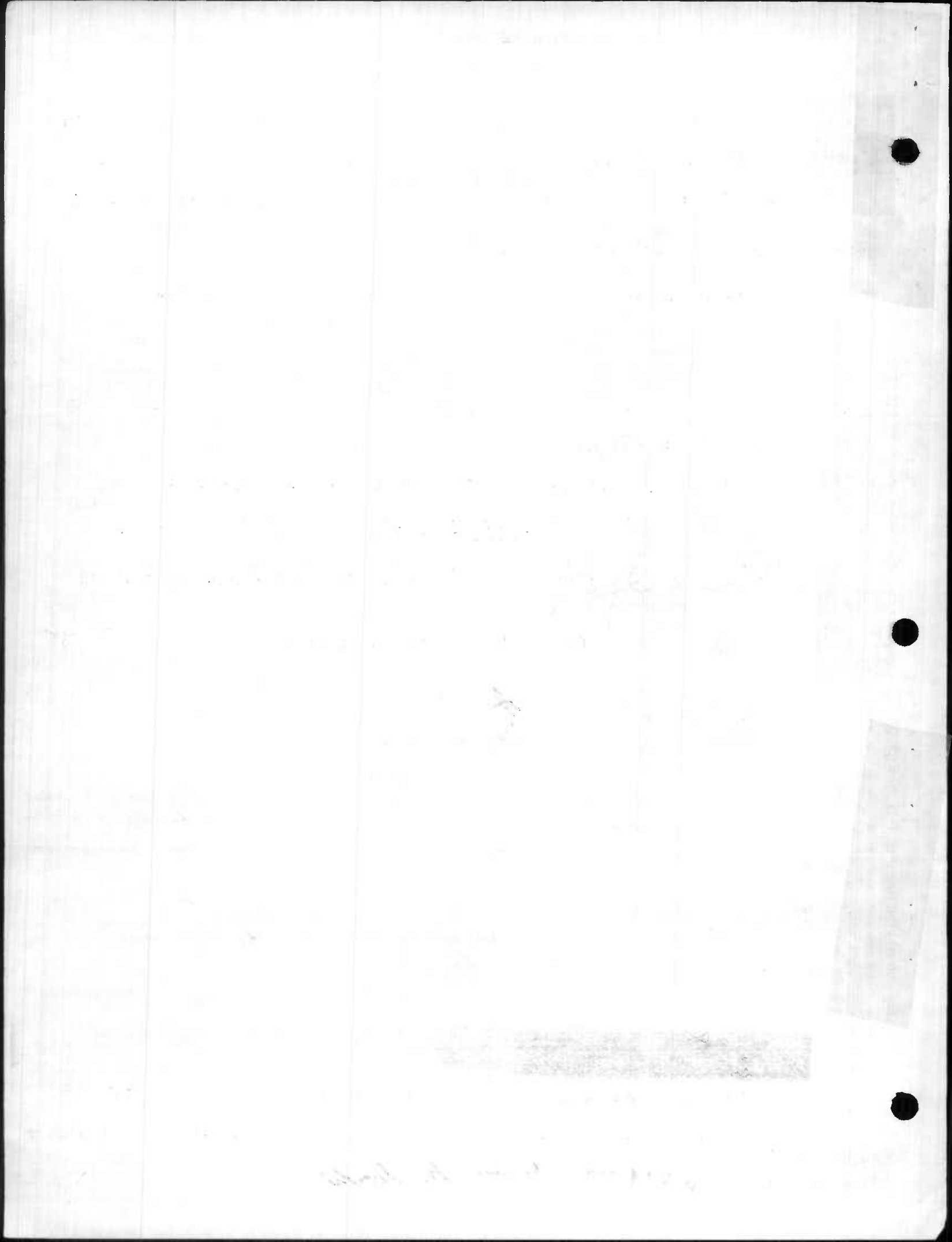
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18956

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Luvonia A. Johnson

2. Date of Death

Month Day Year
May 21 1999

3. Time of Death

1723

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

220-03-1821

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7-23-23

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Upper Hill

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

P.O. Box 303

10f. Zip Code

21868

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th grade

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic Worker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Robert Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Casalever Maddox

19a. Informant's Name/Relationship (Type, Print)

Samuel Johnson (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 312 Upper Hill, Md. 21868

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hardy Family Cemetery

Date

5/29/99

Upper Hill, Md. 21868

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rehnik Smith-Funeral Home
PO Box 331 Pocomoke, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ANOXIC ENCEPHALOPATHY

Approximate Interval Between Onset and Death

1 DAY

Due to (or as a consequence of):

CARBON DIOXIDE NARCOSIS

1 MONTH

Due to (or as a consequence of):

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

3 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. L. Smith, MD

29c. License number

D 46962

29d. Date signed (Month, Day, Year)

MAY 22, 1999.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

M. SHIRAZI, M.D. PENINSULA REGIONAL MEDICAL CENTER, MD 21801.

31. Date filed (Month, Day, Year)

JUN 01 1999

32. Registrar's Signature

B. Sparks

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

Luvonia Johnson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Luvonia Johnson

WRC
99-3049-510
MARIAH J.
MULLINX

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18957

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIAH JEANNENE MULLINX				2. Date of Death Month Day Year MAY 26, 1999		3. Time of Death 9:19 PM.					
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL PEDIATRIC				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death CITY					
Funeral Director	5. Social Security Number 214-49-4450		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 2 Yrs.		8. Date of Birth (Month, Day, Year) 1/20/1997		9. Birthplace (State or Foreign Country) MARYLAND			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD.		10b. County CARROLL		10c. City, Town or Location UNION BRIDGE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1120 CLEAR VIEW RD.				10f. Zip Code 21791		10g. Citizen of What Country? USA.					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NONE			16b. Kind of Business/Industry NONE				
	17. Father's Name (First, Middle, Last) THOMAS EDWARD MULLINX, JR.				18. Mother's Name (First, Middle, Maiden Surname) MARA LEA GOFF							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) FATHER THOMAS E. MULLINX, JR.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 CLEAR VIEW RD., UNION BRIDGE, MD. 21791							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) UNIONTOWN LUTHERAN CEM.				20c. Location - City or Town, State 5/30/99 UNIONTOWN, MD.					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE INJURIES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 5-26-99		28b. Time of Injury 2010 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred LOADER SWING WAS STRUCK BY A SKID 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1120 CLEARVIEW RD CARROLL CO MD				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 27, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANITA KOREN 111 Penn Street, Baltimore, Maryland 21201												
31. Date filed (Month, Day, Year) JUN 02 1999		32. Registrar's Signature 										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18958

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Minnick

2. Date of Death

May 29th 1999

3. Time of Death

1-15AM

4a. Facility Name (If not institution, give street and number)

Pleasant View Nursing Home

4b. City, Town, or Location of Death

Mt. Airy

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

705-10-6024

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct. 30, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Union Bridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

109 N. Main St.

10f. Zip Code

21791

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

inspector

16b. Kind of Business/Industry

railroad

17. Father's Name (First, Middle, Last)

Charles O. Minnick

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Fogle

19a. Informant's Name/Relationship (Type, Print)

R. Neal Hoffman/ attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24 N. Court St. Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Cemetery

Date

6/1/99

20c. Location - City or Town, State

Keysville, MD

21. Signature of Funeral Service Licensee

Catherine O. Hartzler

22. Name and Address of Facility

Hartzler Funeral Home

6 E. Broadway Union Bridge, MD 21791

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Myocardial Infarction

Due to (or as a consequence of):

b.

Coronary Artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 day
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Osteoarthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

N.B. Veauank

29c. License number

D-30469

29d. Date signed (Month, Day, Year)

May 29th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.B. VEUAANK, 9055, CHEVROLET DRIVE, #100, ELLICOTT CITY, MD 21042

State
Registrar

31. Date filed (Month, Day, Year)

JUN 02 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18959

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIAH JAELYN PYATT						2. Date of Death Month MAY Day 20 Year 1999		3. Time of Death 2:52 PM	
	4a. Facility Name (If not Institution, give street and number) NATIONAL NAVAL MEDICAL CENTER						4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number No Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 1		8. Date of Birth (Month, Day, Year) May 19, 1999		9. Birthplace (State or Foreign Country) Bethesda, Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Suitland				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 4226 Apple Gate Lane				10f. Zip Code 20746		10g. Citizen of What Country? United States of America				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -0- College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never Employed			16b. Kind of Business/Industry None			
17. Father's Name (First, Middle, Last) Romy Pyatt						18. Mother's Name (First, Middle, Maiden Surname) Thema Joannique Brooks				
19a. Informant's Name/Relationship (Type, Print) Thema J. Pyatt/ Mother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4226 Apple Gate Lane, Suitland, Maryland 20746				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) New Bethel Cemetery			Date May 28 1999		20c. Location - City or Town, State Pawley's Island South Carolina		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street, Alexandria, VA 22310				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. LETHAL SKELETAL DYSPLASIA Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number D-44634		29d. Date signed (Month, Day, Year) 05/21/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.R. GREENWALD, CDR, MC, USN						NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600				
31. Date filed (Month, Day, Year) JUN 14 1999			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 6876

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18960

Amended item# 7, 6/1/99, WCHD, E.T

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Gary Frederick Redemann				2. Date of Death Month Day Year 6/1/1999		3. Time of Death 2:00 AM	
4a. Facility Name (If not institution, give street and number) 11547 South Dolly Circle				4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester	
5. Social Security Number 214-44-0387		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52. 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4/16/1946	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent							
10a. State MD		10b. County Worcester		10c. City, Town or Location Berlin		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 11547 South Dolly Circle				10f. Zip Code 21811		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 1965/67		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tool and Die Maker		16b. Kind of Business/Industry Can Manufacturer	
17. Father's Name (First, Middle, Last) Marion Michael Redemann				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Garcia			
19a. Informant's Name/Relationship (Type, Print) Patricia Redemann - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11547 South Dolly Circle, Berlin, MD 21811			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Cemetery		20c. Date 6/4/1999		20d. Location - City or Town, State Owings Mills, MD	
21. Signature of Funeral Service Licensee <i>H. G. Burbage</i>				22. Name and Address of Facility 108 Williams St. The Burbage Funeral Home Berlin, MD 21811			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Renal Carcinoma</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Joseph B. McShea</i>				29c. License number A5718		29d. Date signed (Month, Day, Year) 6/1/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Joseph B. McShea D.D 10514 Racetrack Rd Unit C Berlin, MD 21811							
31. Date filed (Month, Day, Year) JUN 01 1999				32. Registrar's Signature <i>Anna B. Sparks</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
pam.1. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18961

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carl Rizzo

2. Date of Death

Month
May

Day

27

Year

1999

3. Time of Death

4:35PM

4a. Facility Name (If not Institution, give street and number)

6345 Davis Road

4b. City, Town, or Location of Death

Mt. Airy

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

207-18-5561

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 16, 1925

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6345 Davis Road

10f. Zip Code

21771

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steamfitter

16b. Kind of Business/Industry

Local 602

17. Father's Name (First, Middle, Last)

Patsy Rizzo

18. Mother's Name (First, Middle, Maiden Surname)

Madeline Visco

19a. Informant's Name/Relationship (Type, Print)

Maxine Tribby Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

123 N. Towne Court Mt. Airy, MD 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem.

Date

6/1/99

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

John B. Corcoran

22. Name and Address of Facility

Burrier-Queen Funeral Directors, P.A.
1212 W. Old Liberty Road Winfield, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Hypertensive Cardiovascular Disease*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Robert L. Kaufmann MD

29c. License number

D-13971

29d. Date signed (Month, Day, Year)

5/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT L. KAUFMANN, MD 300 WEST NINTH STREET
FREDERICK, MD 21701

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

Frederick P. Sparks

State
Registrar

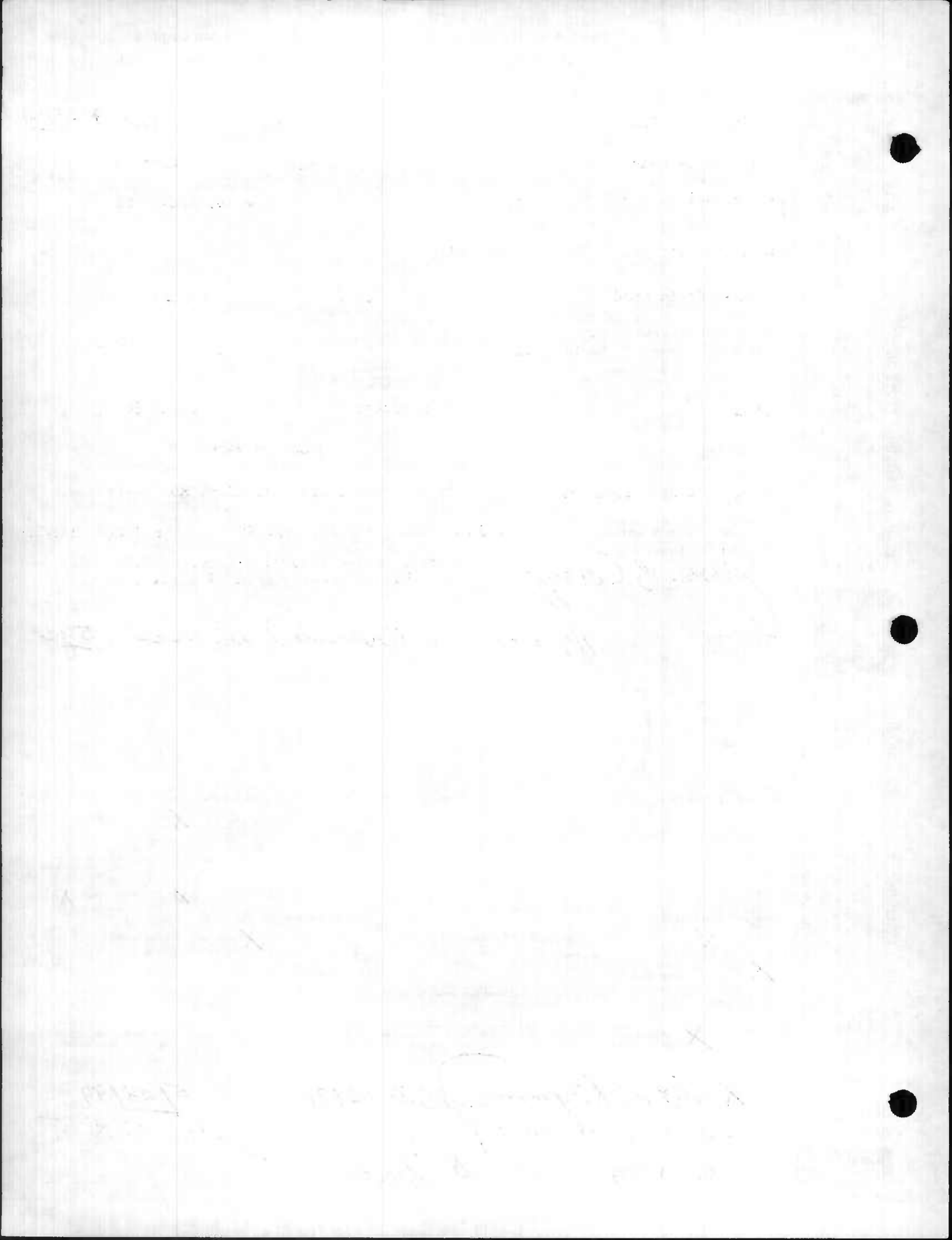
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18962

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY SHETRON

2. Date of Death

Month Day Year
MAY 27 1999

3. Time of Death

1024 AM

4a. Facility Name (If not institution, give street and number)

NORTH WEST HOSPITAL

4b. City, Town, or Location of Death

RANDALSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

220-18-1964

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
4/20/1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

REISTERSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16 MISSION WOOD WAY

10f. Zip Code

21136

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

NURSING ASSISTANT

16b. Kind of Business/Industry

HEALTH

17. Father's Name (First, Middle, Last)

OTHA BROWN

18. Mother's Name (First, Middle, Maiden Surname)

RUTH BERWAGER

19a. Informant's Name/Relationship (Type, Print)

DAWN WORKMAN -DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 MISSION WOOD WAY, REISTERSTOWN, MD. 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ST. MARY'S CEMETERY 5/29/99

Date

20c. Location - City or Town, State

SILVER RUN, MD.

21. Signature of Funeral Service Licensee

B. L. ...

22. Name and Address of Facility

FLETCHER FUNERAL HOME
254 E. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE PULMONARY EDEMA

Due to (or as a consequence of):

b. CONGESTIVE CARDIOMYOPATHY

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. L. ...

29c. License number

D37333

29d. Date signed (Month, Day, Year)

MAY 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. RAVI, MD, NHC, BALTO. MD 21133

State
Registrar

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

B. L. ...

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18963

Funeral Director

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Gordon William Stabb				2. Date of Death Month Day Year MAY 29, 1999				3. Time of Death 10:05 AM			
4a. Facility Name (If not institution, give street and number) 6217 LONG MEADOW DRIVE						4b. City, Town, or Location of Death SYKESVILLE				4c. County of Death CARROLL	
5. Social Security Number NONE		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Nov 18, 1927	
9. Birthplace (State or Foreign Country) England											
Usual Residence of Decedent											
10a. State NONE		10b. County BANFFSHIRE		10c. City, Town or Location ABERLOUR				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number COTTERTON CRAIGELLACHIE						10f. Zip Code NONE			10g. Citizen of What Country? SCOTLAND		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HEAD PORTER				16b. Kind of Business/Industry HOSPITAL			
17. Father's Name (First, Middle, Last) UNKNOWN						18. Mother's Name (First, Middle, Maiden Surname) FLORENCE (UNKNOWN)					
19a. Informant's Name/Relationship (Type, Print) MRS. GRETA POWLEY (WIFE)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COTTERTON CRAIGELLACHIE ABERLOUR BANFFSHIRE, SCOTLAND					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Serv.				20c. Date 5/30/99		20d. Location - City or Town, State Hampstead, MD	
21. Signature of Funeral Service Licensee <i>Brian L. Stagg</i>						22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic cardiovascular disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? INSPECTED 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Maryanne Beithell</i>						29c. License number OCME			29d. Date signed (Month, Day, Year) MAY 29, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANNE BEITHELL 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JUN 01 1999				32. Registrar's Signature <i>Beverly B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18964

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18965

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE ROBERT TOROK

2. Date of Death

MAY 29, 1999

3. Time of Death

12:52 PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

284-48-8457

6. Sex

XXM 20 F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 2, 1952 Ohio

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

XX Yes 20 No

10e. Street and Number

2157 Wainwright Court

10f. Zip Code

21702

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Project Manager

16b. Kind of Business/Industry

Pipeliners

17. Father's Name (First, Middle, Last)

George J. Torok

18. Mother's Name (First, Middle, Maiden Surname)

Julia Szkelyhidi

19a. Informant's Name/Relationship (Type, Print)

Diana Fisher - (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

508 S. Casey Key Rd., Nokomis, Fl. 43275

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Calvary Cemetery

Date

6/3/99

20c. Location - City or Town, State

Dayton, Ohio

21. Signature of Funeral Service Licensee

Paul T. Sochalsky

22. Name and Address of Facility

Inman Nationwide Shipping

6500 Merwin Ave., Cleveland Ohio

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

STREPTOCOCCUS PNEUMONIAE PNEUMONIA.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ACUTE RENAL FAILURE

Due to (or as a consequence of):

5 DAYS

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural

50 Pending investigation

20 Accident

60 Could not be determined

30 Suicide

40 Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician

20 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Neil Warandek

29c. License number

D47611

29d. Date signed (Month, Day, Year)

MAY 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEIL WARANDEK MD 1475 TANEY AVE #204 FREDERICK MARYLAND 21702

31. Date filed (Month, Day, Year)

JUN 14 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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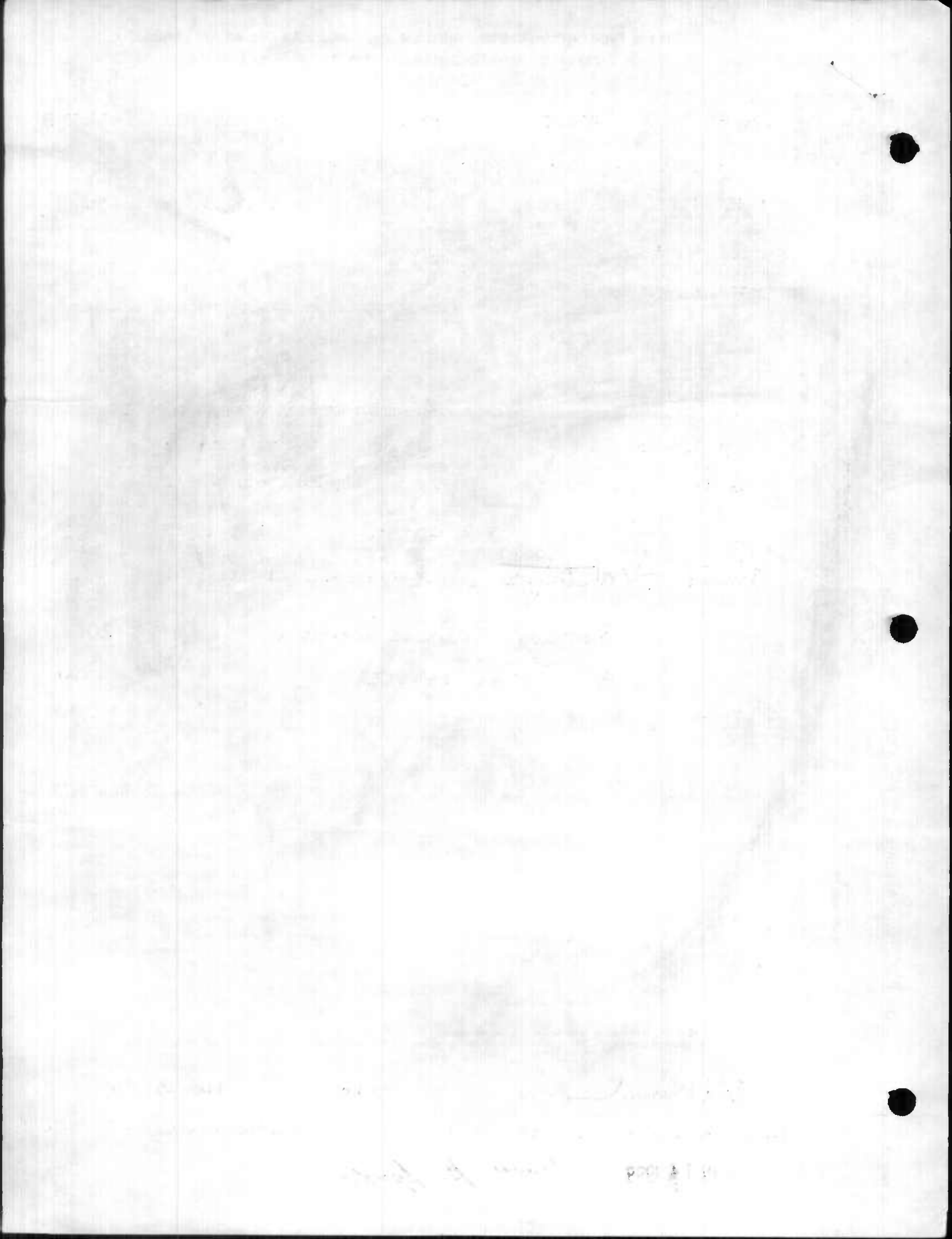
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18966

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Clarence Woolford

2. Date of Death

May 25, 1999

3. Time of Death

8:55 A.M.

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

219-14-2879

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

6-19-23

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12064-Elm Street Apt. 17

10f. Zip Code

21853

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No 12-17-45
If Yes, Give Year or Dates: 8-20-5913. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Reconditioning Cars

16b. Kind of Business/Industry

Auto Dealership

17. Father's Name (First, Middle, Last)

John Woolford Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Emma Winder

19a. Informant's Name/Relationship (Type, Print)

Mildred D. Woolford

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12064-Elm Street - Princess Anne Md. 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Trinity Cemetery

Date

5-29-99

20c. Location - City or Town, State

Venton Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Bennis Smith Funeral Home

P.O. Box 331 - Pocomoke City, Md. 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)
5/25/99

28b. Time of Injury

0742 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred Subject thrown off

vehicle hit by vehicle

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

roadway

28f. Location (Street and Number or Rural Route Number,
City or Town, State)U.S. Route 13 + Route 1
Neck Road in Princess Anne Maryland29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 28 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Certificate of Death

Reg. No.

99 18967

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Mary E. Waldner</u>		2. Date of Death Month <u>5</u> Day <u>27</u> Year <u>99</u>		3. Time of Death <u>10:15AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Carroll Lutheran Village Nursing Home</u>		4b. City, Town, or Location of Death <u>Westminster</u>		4c. County of Death <u>Carroll</u>	
Funeral Director	5. Social Security Number <u>216-14-4653</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>75</u> Yrs.	
	8. Date of Birth (Month, Day, Year) <u>12/11/1923</u>		9. Birthplace (State or Foreign Country) <u>MARYLAND</u>			
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State <u>MD.</u>		10b. County <u>CARROLL</u>		10c. City, Town or Location <u>REISTERSTOWN</u>	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number <u>3703 CLYDESDALE RD.</u>		10f. Zip Code <u>21136</u>		10g. Citizen of What Country? <u>USA.</u>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>SECRETARY</u>		16b. Kind of Business/Industry <u>EDUCATION</u>	
	17. Father's Name (First, Middle, Last) <u>CHARLES F. JOHNSON</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>HELEN ROSE KENNEDY</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>GEORGE C. WALDNER -HUSBAND</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3703 CLYDESDALE RD., REISTERSTOWN, MD. 21136</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>MD. VETERANS CEMETERY</u>		20c. Location - City or Town, State <u>6/1/99 OWINGS MILLS, Md.</u>	
21. Signature of Funeral Service Licensee <u>Nancy K. Fletcher</u>		22. Name and Address of Facility <u>FLETCHER FUNERAL HOME</u> <u>254 E. MAIN ST., WESTMINSTER, MD. 21157</u>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. <u>Metastatic Squamous Cell CA @ lung</u> Due to (or as a consequence of): b. <u>Brain Metastasis</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death <u>few mos</u> <u>few wks</u>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cerebral Edema</u>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D37949</u>		29d. Date signed (Month, Day, Year) <u>May 27th 1999</u>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Alexander Bydaschewsky 205 St. Mark Way, Westminster, MD 21157</u>					
31. Date filed (Month, Day, Year) <u>MAY 28 1999</u>		32. Registrar's Signature <u>B. Sparks</u>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18968

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ADELE H. ANDREWS						2. Date of Death Month Day Year June 12 1999		3. Time of Death 10:37A	
	4a. Facility Name (If not institution, give street and number) Fallston General Hospital						4b. City, Town, or Location of Death Fallston		4c. County of Death Harford	
Funeral Director	5. Social Security Number 142-09-3084		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) March 4, 1920		9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1314 Southwell Lane				10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Budget Analyst		16b. Kind of Business/Industry U.S. Government				
17. Father's Name (First, Middle, Last) Louis Derensiye						18. Mother's Name (First, Middle, Maiden Surname) Mali (Unknown)				
19a. Informant's Name/Relationship (Type, Print) John L. Szarka (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Streamside Drive, Fallston, MD. 21047						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens		20c. Date 6/15/99		20d. Location - City or Town, State Bel Air, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE INFERIOR MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ADULT ONSET DIABETES MELITUS Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 10 HOURS 10 YEARS		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D16036		
				29d. Date signed (Month, Day, Year) JUNE 13, 1999						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dean L. Vassar 104 Plumtree Rd Bel Air Maryland 21015										
31. Date filed (Month, Day, Year) JUN 15 1999				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18969

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward Lee Atkins						2. Date of Death Month Day Year JUNE 9, 1999		3. Time of Death 1519 PM		
	4a. Facility Name (If not institution, give street and number) 124 W. FRANKLIN STREET APT. #414						4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death n/a		
Funeral Director	5. Social Security Number 214-24-5537		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) May 29, 1925		9. Birthplace (State or Foreign Country) Va.		
	Usual Residence of Decedent										
10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 124 W. Franklin Street Apt. 414				10f. Zip Code 21225		10g. Citizen of What Country? USA					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant Seaman				16b. Kind of Business/Industry Seafarers Union			
17. Father's Name (First, Middle, Last) Thomas Atkins						18. Mother's Name (First, Middle, Maiden Surname) Frances Mitchell					
19a. Informant's Name/Relationship (Type, Print) cousin Olellian M. Hill						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3217 Northmont Road Baltimore, Md. 21244					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date June 15		20c. Location - City or Town, State Baltimore, Md.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216							
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? partial 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number OCME		29d. Date signed (Month, Day, Year) JUNE 10, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JUN 15 1999				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

James M. Smith

and C. Smith, 1884

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18970

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rebecca Arthur				2. Date of Death Month Day Year June 6, 1999		3. Time of Death 8:30 pm		
	4a. Facility Name (If not institution, give street and number) 130 Hearne Road Apt. 1004				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 218-42-9433		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 21, 1944		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 130 Hearne Road Apt. 1004		10f. Zip Code 21401		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auditor		16b. Kind of Business/Industry St. of Md. Income Tax				
	17. Father's Name (First, Middle, Last) Thomas H. Briddell				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Barnes				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Bonnie B. Griffith - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Wildernest Lane, Port Matilda, PA 16870				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans cem		Data 6/10		20c. Location - City or Town, State Crownsville, MD		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Robert A. Clark</i>				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Coronary artery disease</i> Due to (or as a consequence of): b. <i>Hypertension</i> Due to (or as a consequence of): c. <i>Morbid obesity</i> Due to (or as a consequence of): d. <i>COPD</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1995 1990 1990 1990	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <i>James W. Ruppel</i>		29c. License number D25499		29d. Date signed (Month, Day, Year) 6/8/99				
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James W. Ruppel 180 Admiral Cochrane Dr Annapolis, MD 21403								
	31. Date filed (Month, Day, Year) JUN 15 1999		32. Registrar's Signature <i>Genevieve S. Sparks</i>						

State of Maryland / Department of Health and Mental Hygiene 99 18971
Certificate of Death Reg. No.

Certificate of Death

Reg. No.

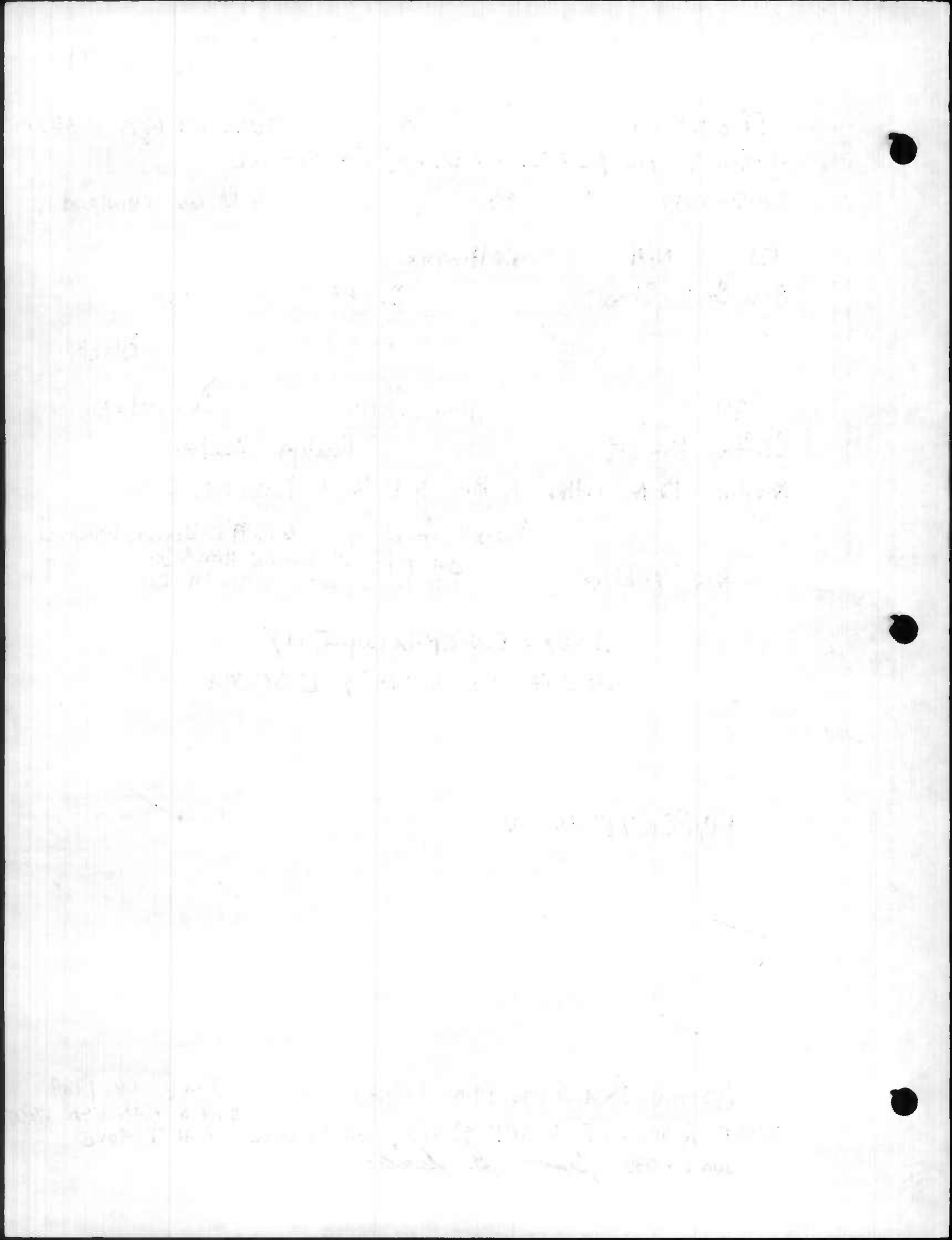
Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18972

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELEANOR JOHANNA BUCKLEY		2. Date of Death Month Day Year JUNE 11, 1999		3. Time of Death 7:00 P.M.
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL		4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 220-03-9515	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) FEB. 4, 1914		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10a. State MARYLAND	10b. County ANNE ARUNDEL	MILLERSVILLE		
	10e. Street and Number 8366 BROCKWOOD		10f. Zip Code 21108		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) College		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOK BINDER		16b. Kind of Business/Industry BINDERY		
	17. Father's Name (First, Middle, Last) ELDRIDGE TROTT		18. Mother's Name (First, Middle, Maiden Surname) VIOLA (UNKNOWN)		
	19a. Informant's Name/Relationship (Type, Print) DOLORES J. BEATTY (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 244 SEVERN ROAD, MILLERSVILLE, MARYLAND 21108		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CENTER LLC.		20c. Location - City or Town, State STEVENSVILLE, MD.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):				Approximate Interval Between Onset and Death 5 YEARS
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE CHRONIC ATRIAL FIBRILLATION				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier MD		29c. License number D 21776		29d. Date signed (Month, Day, Year) JUNE 14 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURYA MUNDRA MD 3001 S. HANOVER ST BALTIMORE 21225					
State Registrar	31. Date filed (Month, Day, Year) JUN 15 1999		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18973

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paula L Butler

2. Date of Death

June 11, 1999

3. Time of Death

16:30

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-96-0369

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

30 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 15, 1968

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

Maryland

10a. State

Baltimore

10b. County

10c. City, Town or Location

Woodlawn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3414 Aurora

Apt. J

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th Grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assistant Manager

16b. Kind of Business/Industry

Advance Bank

17. Father's Name (First, Middle, Last)

John Butler

18. Mother's Name (First, Middle, Maiden Surname)

Grace Barnes

19a. Informant's Name/Relationship (Type, Print)

Grace Butler - mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3506 Hillsmere Ave. Baltimore, Maryland 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

6-18

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kevin Parker

22. Name and Address of Facility

Kevin A. Parker Funeral Home
3512 Frederick Ave. Baltimore, MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adult respiratory distress syndrome

Approximate Interval Between Onset and Death

1 week

Due to (or as a consequence of):

b. Sepsis

8 days

Due to (or as a consequence of):

c. Small bowel infarction

8 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Morbid obesity

Ventral hernia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Philip McDowell, M.D.

29c. License number

D47221

29d. Date signed (Month, Day, Year)

June 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip McDowell, M.D. Northwest Hospital Center Randallstown Maryland

31. Date filed (Month, Day, Year)

JUN 15 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18974

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Laura B. Bordley				2. Date of Death Month Day Year June 12 1999				3. Time of Death 7:14A.M.		
	4a. Facility Name (If not institution, give street and number) 1624 Burrissville Road				4b. City, Town, or Location of Death Centreville				4c. County of Death Queen Anne		
Funeral Director	5. Social Security Number 217-42-7256		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 26, 1944		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent				10a. State Maryland				10b. County Queen Anne		
10c. City, Town or Location Centreville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 1624 Burrissville Road				10f. Zip Code 21617				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: Black				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Immigration Service Worker			
16b. Kind of Business/Industry Federal Government				17. Father's Name (First, Middle, Last) William Henry Bonds				18. Mother's Name (First, Middle, Maiden Surname) Sarah Morris			
19a. Informant's Name/Relationship (Type, Print) Morris P. Bonds (brother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 443, Centreville, Maryland 21617							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesterfield Cemetery				20c. Location - City or Town, State 6/16/99 Centreville, Maryland			
21. Signature of Funeral Service Licensee				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Adenocarcinoma of Pancreas Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cemo- Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)				28b. Time of Injury M			
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature]				29c. License number 4142587				29d. Date signed (Month, Day, Year) 6/14/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell A. Schilling, D.O., 2540 Centreville R. Centreville, Maryland 21617				31. Date filed (Month, Day, Year) JUN 15 1999				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MICHAEL BATES

ITEMS: #23 PART 1, 11, 27, 28A-F PER MEO G772 6-18-99 W Certificate of Death

Reg. No. 99 18975

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Michael Bates</i>				2. Date of Death Month <i>JUNE</i> Day <i>6</i> Year <i>1999</i>		3. Time of Death <i>0732 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>3800 BOARMAN AVENUE</i>				4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>220-50-2128</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>50</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>AUG 13, 1948</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>Md.</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>3411 Powhatan Ave.</i>		10f. Zip Code <i>21216</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>laborer</i>		16b. Kind of Business/Industry <i>Home Improvement</i>				
17. Father's Name (First, Middle, Last) <i>Gilbert Bates</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Bernice Little</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Bernice Bates</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3411 Powhatan Ave. Balt. Md. 21216</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenmount Cemetery</i>		20c. Location - City or Town, State <i>6/9/99 Baltimore, Md.</i>				
21. Signature of Funeral Service Licensee <i>Carlton C. Douglas</i>				21. Name and Address of Facility <i>Douglas Funeral Service 1701 McCulloh St.</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>NARCOTIC INTOXICATION</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i>								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>AT SCENE</i>						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>Found: 6-6-99</i>		28b. Time of Injury <i>Found: 6:50</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <i>SUBJECT INGESTED DRUGS</i>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>FOUND IN HOUSE</i>						
28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>BALTIMORE, MARYLAND</i>								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i>		29c. License number <i>O.C.M.E</i>		29d. Date signed (Month, Day, Year) <i>JUNE 7, 1999</i>				
30. Name and address of person who completed cause of death (Reg. 23a) (Type, Print) <i>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</i>								
31. Date filed (Month, Day, Year) <i>JUN 15 1999</i>		32. Registrar's Signature <i>S. Sparks</i>						

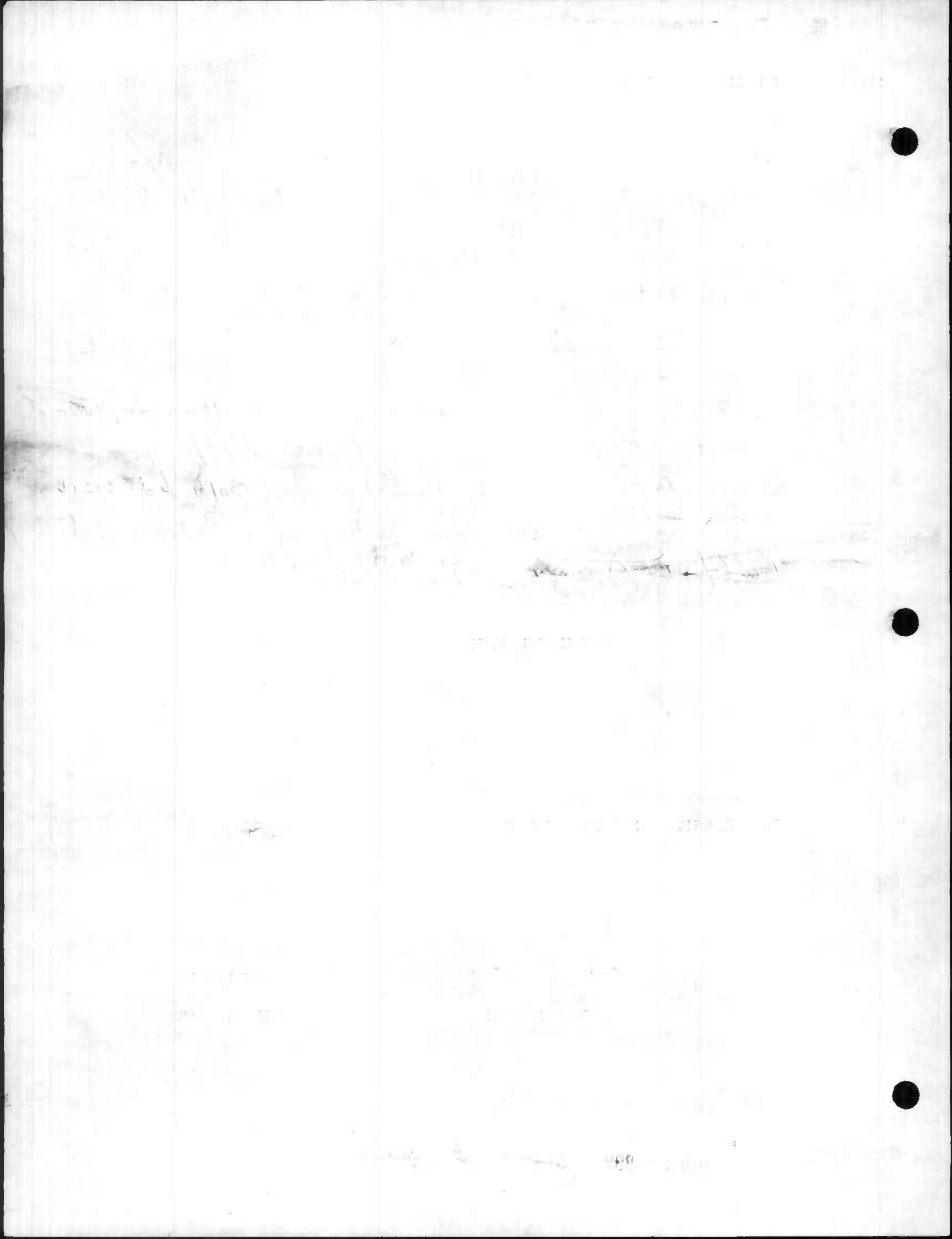
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18976

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BONNIE MARIE BUCK						2. Date of Death Month Day Year June 09, 1999		3. Time of Death 2:20 P.M.	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital						4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-70-3050		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 13 1955		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Middle River				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 2133 Oakland Ave.				10f. Zip Code 21220		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager			16b. Kind of Business/Industry Tempo Lounge		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John O. Wimmer						18. Mother's Name (First, Middle, Maiden Surname) Mary Linkerhocker			
	19a. Informant's Name/Relationship (Type, Print) Dawn Marie Buck/daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2133 Oakland Ave. Baltimore Md. 21220			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 6/14/99				20c. Location - City or Town, State Baltimore Md.			
	21. Signature of Funeral Service Licensee R. Terry Connolly						22. Name and Address of Facility Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Pulmonary Thromboembolism due to Deep Vein Thrombosis of Right Leg Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Theodore M. King				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 11, 1999	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201									
	31. Date filed (Month, Day, Year) JUN 15 1999		32. Registrar's Signature B. Sparks							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

18977

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MYRTLE M BOBART				2. Date of Death Month Day Year JUNE 13 1999				3. Time of Death 5:00am	
	4a. Facility Name (If not institution, give street and number) 125 Riverside Road				4b. City, Town, or Location of Death Essex				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-38-3107		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 7 1904		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 125 Riverside Road				10f. Zip Code 21221		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry own home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John R. Campbell				18. Mother's Name (First, Middle, Maiden Surname) Ida May Johnson					
	19a. Informant's Name/Relationship (Type, Print) George Bobart / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 Calusa Lakes Blvd. Nikomis Fla. 34275					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery 6/16/99				20c. Location - City or Town, State Baltimore Md.			
	21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Maryland 21221					
Physician /Medical Examiner	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute myocardial infarct, causing sudden death Due to (or as a consequence of): Coronary artery disease - Chronic renal insufficiency									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined									
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier R. Terry Connelly				29c. License number D10613		29d. Date signed (Month, Day, Year) 6-15-99			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAPHAEL PEREZ-THERIA 404 EASTERN BLVD 21221									
	31. Date filed (Month, Day, Year) JUN 15 1999		32. Registrar's Signature B. Sparks							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18978

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Franklin Henry Bradshaw, Sr.				2. Date of Death Month Day Year June 08, 1999		3. Time of Death 11:45 P.M.		
	4a. Facility Name (If not institution, give street and number) Route 70 East-bound near Frederick Co. line				4b. City, Town, or Location of Death Myersville		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 213-54-9870	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 18, 1947		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent								
10a. State MD		10b. County		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 2502 Wagner Avenue				10f. Zip Code 21219		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1969-70		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver			16b. Kind of Business/Industry Transportation		
17. Father's Name (First, Middle, Last) Sollis Bradshaw				18. Mother's Name (First, Middle, Maiden Surname) Jenny Brown					
19a. Informant's Name/Relationship (Type, Print) Cora Louise Bradshaw (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2502 Wagner Avenue, Baltimore, MD 21219					
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.		Data 06/14		20c. Location - City or Town, State Crownsville, MD			
21. Signature of Funeral Service Licensee <i>Patrick J. Smith</i>				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Compassional Asphyxiation and Multiple Injuries</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6-8-99		28b. Time of Injury 11:00 P M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred motor vehicle collision	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street				28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt 70 Myersville, Md			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Dennis J. Chute</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 10, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JUN 15 1999		32. Registrar's Signature <i>B. Sparks</i>							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18979

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Brown				2. Date of Death Month Day Year June 9 1999		3. Time of Death 1:15 PM	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-28-7310		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 10, 1934	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 2530 W. Mosher St.		10f. Zip Code 21216		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Watercraft Operator		16b. Kind of Business/Industry U.S. Army			
	17. Father's Name (First, Middle, Last) Wallace Warren Brown		18. Mother's Name (First, Middle, Maiden Surname) Nancy Williams		19a. Informant's Name/Relationship (Type, Print) (Brother) Mr. Paul Brown		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8144 Quarterfield Farms Drive Severn, Md. 21144	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest		20c. Location - City or Town, State Cwings Mills, Md.		20d. Date 6/15/99	
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hemoptysis Due to (or as a consequence of): Non small cell carcinoma of the lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5 years		Approximate Interval Between Onset and Death 1 hr	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Glenn Robert Meiningger, MD		29c. License number RES-000		29d. Date signed (Month, Day, Year) 6/9/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn Robert Meiningger, Johns Hopkins Hospital, Baltimore, MD 21287		31. Date filed (Month, Day, Year) JUN 15 1999		32. Registrar's Signature B. Sparks			

WRC
99-3249-005
AARON
BROWN

ITEM: #20B PER F.H. G772

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18980

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Aaron N. Brown				2. Date of Death Month Day Year JUNE 08, 1999		3. Time of Death 4:35 PM.		
	4a. Facility Name (If not institution, give street and number) NORTHWAET HOSPITAL				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 217-98-6284		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 17 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 1, 1982		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 762 Carroll St.		10f. Zip Code 21230			
10g. Citizen of What Country? USA		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: Afro-American		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry School			
17. Father's Name (First, Middle, Last) Gregory Brown Sr.				18. Mother's Name (First, Middle, Maiden Surname) Lillie Spears					
19a. Informant's Name/Relationship (Type, Print) Mr. Gregory Brown Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 762 Carroll St. Balto, Md. 21230					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION		20c. Date 6/15/99		20d. Location - City or Town, State BALTIMORE, MD.			
21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Drowning Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) June 6-8-99		28b. Time of Injury 1605P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred Swiss Drown		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Swimming Pool		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3900 Wilkes Hill Rd. Randallstown, MD					
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Wayne Marshall				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JUNE 09, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MS Ryan Korman 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JUN 15 1999		32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18981

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

DOROTHY

BRIMER

2. Date of Death

June

Day

13

Year

1999

3. Time of Death

2:18 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

499-30-8499

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 17, 1931

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

154 W. Chestnut Hill Lane

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
616a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Management Assistant

16b. Kind of Business/Industry

Social Security

17. Father's Name (First, Middle, Last)

R. Kipp Briney

18. Mother's Name (First, Middle, Maiden Surname)

Lena Higgins

19a. Informant's Name/Relationship (Type, Print)

Roy Brimer Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

154 W. Chestnut Hill Lane, Reisterstown, MD 21136

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Carroll Cremation Ser.

Date

6/16/99 Hamstead, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

11824 Reisterstown Rd.
Eline Funeral Home Reisterstown, MD 2113623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. ATHEROSCLEROTIC HEART DISEASE
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Susan W. Owens MD

29c. License number

D22751

29d. Date signed (Month, Day, Year)

June 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan W. Owens, MD NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, Maryland

31. Date filed (Month, Day, Year)

JUN 15 1999

32. Registrar's Signature

B. A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

A412

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 18982

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Elizabeth Bowen

2. Date of Death

June 13, 1999

3. Time of Death

1:04 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Catonsville

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-05-1427

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 15, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

98 Smithwood Ave.

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

"unlc"

College (1-4 or 5+)

"unlc"

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Worker

16b. Kind of Business/Industry

Business

17. Father's Name (First, Middle, Last)

Abram Gary Bowen

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Mae Hall

19a. Informant's Name/Relationship (Type, Print)

Mr. Thomas Gary Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10904 Middleboro Dr. Demascus, Maryland 20872

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

06/14/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Respiratory Failure

1d

Due to (or as a consequence of):

b.

chronic obstructive lung disease

5 yr.

Due to (or as a consequence of):

c.

chronic obstructive disease

5 yr.

Due to (or as a consequence of):

d.

Dementia

5 yr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D 29769

6/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mrs. Christine D. Bowen 1120 W. Kelly Rd Bn Hs.

31. Date filed (Month, Day, Year)

JUN 15 1999

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18983

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TONI COOK				2. Date of Death Month Day Year JUNE 07 1999		3. Time of Death 14:05 pm		
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CTR				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death MD 21224		
Funeral Director	5. Social Security Number UNK	6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	7. Age (In yrs. last birthday) 49	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 04/17/1950		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent								
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 312 E. North Ave.				10f. Zip Code 21202		10g. Citizen of What Country? U.S.A			
11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER			16b. Kind of Business/Industry CONSTRUCTION		
17. Father's Name (First, Middle, Last) FREDERICK V. COOK					18. Mother's Name (First, Middle, Maiden Surname) MYRTLE MURRAY				
19a. Informant's Name/Relationship (Type, Print) MYRTLE GOODWIN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7909 FREETOWN RD. GLEN BURNIE 21060					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION		Date 6/11/99		20c. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee James A. Morton				22. Name and Address of Facility JAMES A. MORTON & SONS F. H., INC. 1701 LAURENS ST. BALTO., MD 21217					
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. AIDS Due to (or as a consequence of): c. HIV Due to (or as a consequence of): d. IV Drug Abuse								Approximate Interval Between Onset and Death 9 days 1 year 1 year 10 years.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumothorax Subcutaneous Emphysema Pneumomediastinum						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier AR Khan, MD		29c. License number 99005		29d. Date signed (Month, Day, Year) JUNE/07/1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS BAYVIEW MEDICAL CTR, DEPT OF MEDICINE, 4940 EASTERN AVENUE BALTIMORE MD 21224									
31. Date filed (Month, Day, Year) JUN 15 1999			32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18984

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Nancy Cooper

2. Date of Death

Month Day Year
JUNE 08 1999

3. Time of Death

09:44 AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-03-3640

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Feb 26, 1928

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10e. State
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

430 Rosecraft Terrace

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

unknown

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

A.B. Stern

18. Mother's Name (First, Middle, Maiden Surname)

Lula Coughman

19a. Informant's Name/Relationship (Type, Print)

Nancy Smith - niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

430 Rosecraft Terrace Baltimore, Maryland 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

6/14

20c. Location - City or Town, State

Landsdowne MD.

21. Signature of Funeral Service Licensee

Kevin Parker

22. Name and Address of Facility

Kevin A. Parker Funeral Home
3512 Frederick Ave. Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Approximate Interval Between Onset and Death

2 weeks

Due to (or as a consequence of):

b. Gastrointestinal bleed

2 days

Due to (or as a consequence of):

c. ANEMIA

1 year

Due to (or as a consequence of):

d. Diabetes mellitus

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

stroke, Diverticulosis, Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel Feinstein, MD House officer

29c. License number

P12590

29d. Date signed (Month, Day, Year)

JUNE 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Feinstein, MD 900 Cuthbert Ave Baltimore, Maryland 21229

31. Date filed (Month, Day, Year)

JUN 15 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

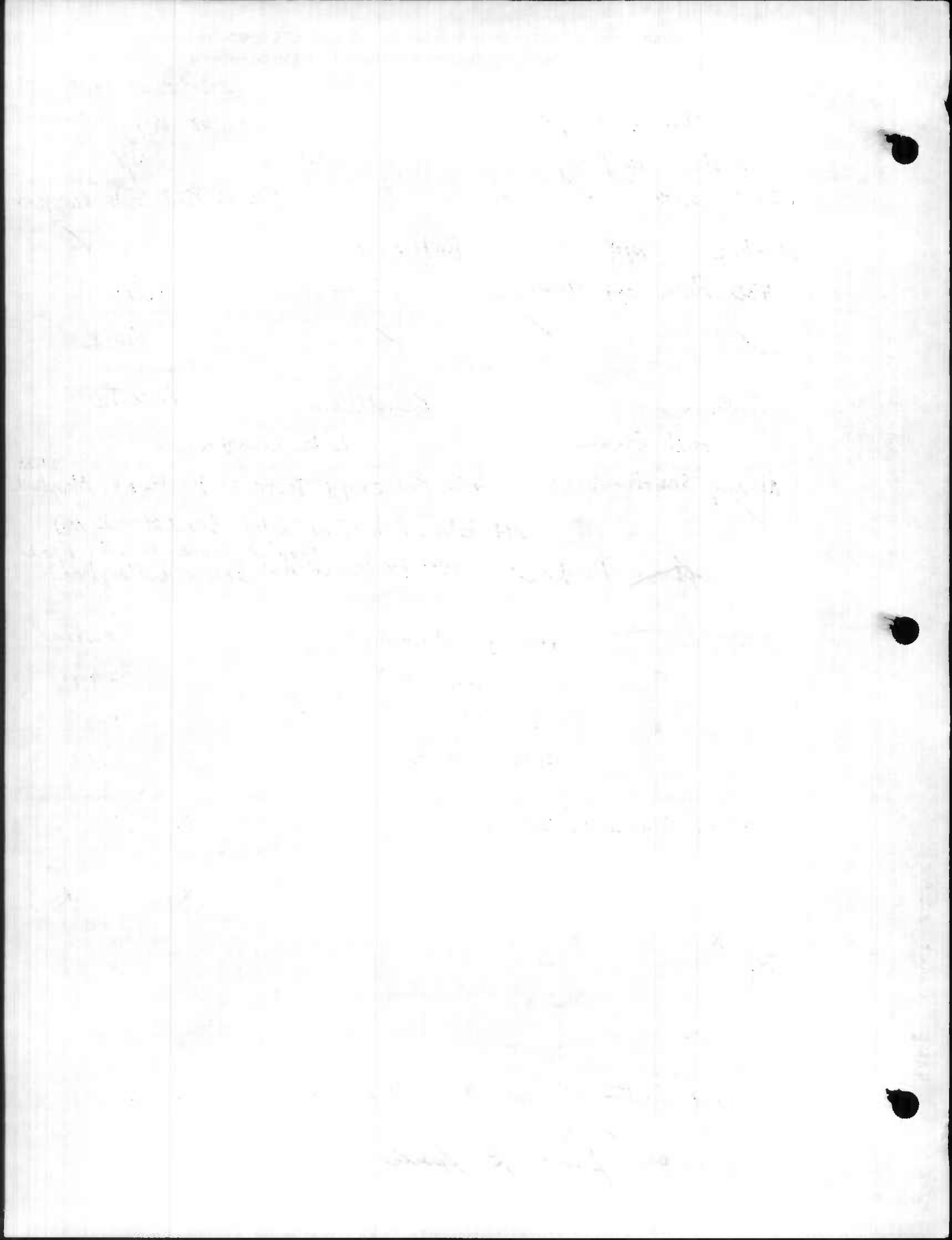
Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME NANCY COOPER

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18985

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIAN A. CADY				2. Date of Death Month Day Year June 10 1999		3. Time of Death 7:30 am	
	4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 212-03-6044		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) 11-12-1904	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location TOWSON	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2300 DULANEY VALLY ROAD		10f. Zip Code 21204		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY		16b. Kind of Business/Industry TELEPHONE COMPANY			
	17. Father's Name (First, Middle, Last) WILLIAM P. CADY				18. Mother's Name (First, Middle, Maiden Surname) MARIAN MULKERIN			
	19a. Informant's Name/Relationship (Type, Print) WILMER F. CADY, JR. (NEPHEW)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3713 YOLANDO AVENUE, BALTIMORE, MD., 21218			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY		20c. Location - City or Town, State 6-14 BALTO., MD., 21229		20d. Date	
	21. Signature of Funeral Service Licensee R. D. Keith				22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. END STAGE DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Months							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number D43725		29d. Date signed (Month, Day, Year) 6/11/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tariq Mahmood, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093							
State Registrar	31. Date filed (Month, Day, Year) 5 1999		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

NAME: CADY MARIAN

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18986

ITEM#23A PRT I & PRT II 27,-28a-f G772 6-17-99 J.A.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carson Oliver Curtis				2. Date of Death Month Day Year June 09, 1999		3. Time of Death 11:00 A.M.		
	4a. Facility Name (If not institution, give street and number) Liberty Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 214-64-1020		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) 10 18 1955		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore City		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1808 N. Dukeland Street		10f. Zip Code 21216		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry Apartment		17. Father's Name (First, Middle, Last) Edward N. Curtis		18. Mother's Name (First, Middle, Maiden Surname) Inez Matthews	
19a. Informant's Name/Relationship (Type, Print) Delroy T. Curtis/Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1808 N. Dukeland Street, Baltimore, Md 21216		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Western Star		20c. Location - City or Town, State 6/15/99 Catonsville, Md.	
21. Signature of Funeral Service Representative 		22. Name and Address of Facility William C. Brown Community Funeral Home 1206 W. North Avenue, Balt. Md. 21217		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERI- RENAL ABSCESS SEIZURE DISORDER		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) FOUND 6-9-99		28b. Time of Injury UNKNOWN	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1808 N. DUKELAND STREET BALTIMORE, MARYLAND			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 10, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute		31. Date filed (Month, Day, Year) JUN 15 1999		32. Registrar's Signature 		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18987

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roland James Combs						2. Date of Death Month Day Year June 13, 1999		3. Time of Death 9:15 AM										
	4a. Facility Name (If not institution, give street and number) 2216 Rockhaven Ave.						4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore										
Funeral Director	5. Social Security Number 213-30-9772		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) March 11, 1933		9. Birthplace (State or Foreign Country) West Virginia										
	Usual Residence of Decedent																		
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number 2216 Rockhaven Ave.				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.													
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder			16b. Kind of Business/Industry Flour Mill												
17. Father's Name (First, Middle, Last) James Elvin Combs						18. Mother's Name (First, Middle, Maiden Summa) Minnie E. Lofton													
19a. Informant's Name/Relationship (Type, Print) Ms. Marian Combs Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Rockhaven Ave. Catonsville, Maryland 21228													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Cemetery			20c. Date 06/16/99		20d. Location - City or Town, State Ellicott City, Maryland											
21. Signature of Funeral Service Licensee <i>[Signature]</i> MOOS35						22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>ACUTE MYELOID LEUKEMIA</td> <td rowspan="4"> Approximate Interval Between Onset and Death 1 YR. 3 YR. </td> </tr> <tr> <td>b.</td> <td>MYELODYSPLASIA</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	ACUTE MYELOID LEUKEMIA	Approximate Interval Between Onset and Death 1 YR. 3 YR.	b.	MYELODYSPLASIA	c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	ACUTE MYELOID LEUKEMIA	Approximate Interval Between Onset and Death 1 YR. 3 YR.																
	b.	MYELODYSPLASIA																	
	c.																		
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred										
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <i>[Signature]</i> MD						29c. License number D08246		29d. Date signed (Month, Day, Year) 6/14/99											
30. Name and address of person who completed cause of death (from 23a) (Type, Print) Breast Cancer Center 22 S. Greene St. Balt. Md. 21201																			
31. Date filed (Month, Day, Year) JUN 15 1999			32. Registrar's Signature <i>[Signature]</i> B. Sparks																

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 18988**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Grace Myra DuBois** 2. Date of Death Month **June** Day **10** Year **1999** 3. Time of Death **8:52 PM**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **Anne Arundel Medical Center** 4b. City, Town, or Location of Death **Annapolis** 4c. County of Death **Anne Arundel**

5. Social Security Number **219-76-8793** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **55** Yrs. 8. Date of Birth (Month, Day, Year) **SEP 24, 1943** 9. Birthplace (State or Foreign Country) **Pennsylvania**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Anne Arundel** 10c. City, Town or Location **Annapolis** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **12 Sargent Court** 10f. Zip Code **21401** 10g. Citizen of What Country? **USA**

11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **0** College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Crafts** 16b. Kind of Business/Industry **Sheltered Workshop**

17. Father's Name (First, Middle, Last) **Horace Conard DuBois** 18. Mother's Name (First, Middle, Maiden Surname) **Edith Kathryn Wiest**

19a. Informant's Name/Relationship (Type, Print) **Muriel Ross Griffith/Half-Sister** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **204 Gloucester Dr. Glen Burnie, MD 21061**

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Metro Crematory, Inc.** Date **6/12/99** 20c. Location - City or Town, State **Baltimore, MD**

21. Signature of Funeral Service Licensee **Edward A. Gnegorchik** 22. Name and Address of Facility **Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Pneumonia** Approximate Interval Between Onset and Death **5 DAYS**

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accidental ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **Edward A. Gnegorchik** 29c. License number **DM 35494** 29d. Date signed (Month, Day, Year) **6/11/99**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Steven Resnick Anne Arundel Medical Center**

31. Data filed (Month, Day, Year) **JUN 15 1999** 32. Registrar's Signature **Barbara B. Sparks**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, 10

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18989

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Doris C. Davis

2. Date of Death

Month Day Year
June 12, 1999

3. Time of Death

8:00 PM

4a. Facility Name (If not institution, give street and number)

Genesis Elder Care-Brightwood Center

4b. City, Town, or Location of Death

Brooklandville

4c. County of Death

Baltimore Co.

5. Social Security Number

172-32-8719

6. Sex

☐ M ☒ F

7. Age (in yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 05, 1905

9. Birthplace (State or Foreign Country)

Salem, Mass.

Usual Residence of Decedent

10a. State

PA.

10b. County

Erie Co.

10c. City, Town or Location

Erie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5416 East Lake Road

10f. Zip Code

16511

10g. Citizen of What Country?

United States of America

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

01

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas V. Chandler

18. Mother's Name (First, Middle, Maiden Summa)

Katherine Morris

19a. Informant's Name/Relationship (Type, Print)

Mrs. Feather Ann Davis (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5001 Wetheredsville Road Baltimore, Maryland 21207-6641

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hilltop Service Corporation

Date

6/14/1999

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

End stage Dementia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Unknown

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aneurysm

Diabetes

Atrial fib

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Allen Hottelmann

29c. License number

D27569

29d. Date signed (Month, Day, Year)

6/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Hottelmann 1838 Greene Tree Rd #300

31. Date filed (Month, Day, Year)

JUN 15 1999

32. Registrar's Signature

B. Sparks

State
Registrar

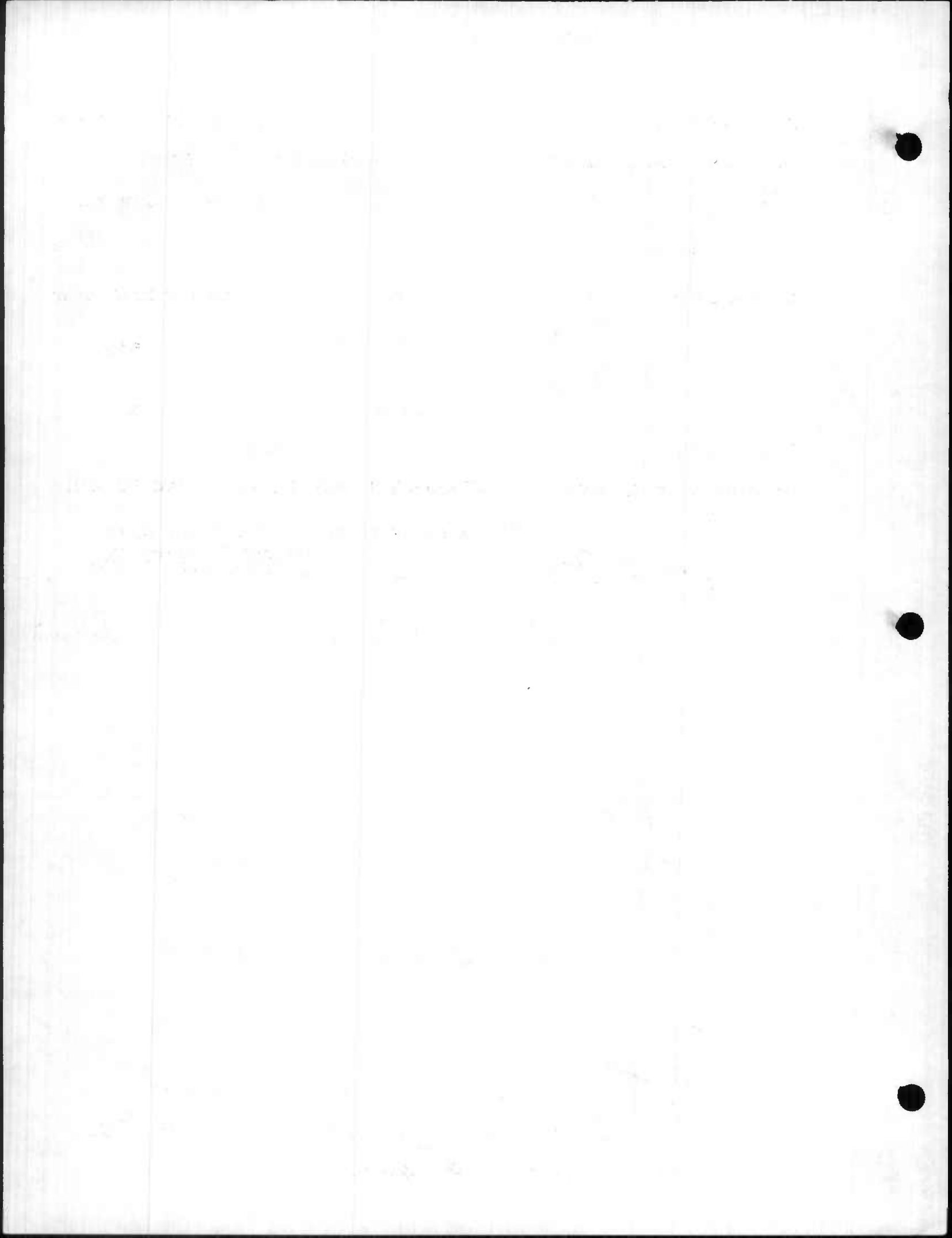
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18990

NAME: Derwart, Andrew

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Andrew J. Derwart				2. Date of Death Month Day Year JUNE 10, 1999		3. Time of Death 3:30PM	
4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
5. Social Security Number 212-07-5343		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 6, 1916	
9. Birthplace (State or Foreign Country) Maryland							
10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Carney		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2917 Erie Avenue				10f. Zip Code 21234		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contract Administrator		16b. Kind of Business/Industry Baltimore City Interstate Highways			
17. Father's Name (First, Middle, Last) Andrew Michael Derwart				18. Mother's Name (First, Middle, Maiden Surname) Teresa Kinlein			
19a. Informant's Name/Relationship (Type, Print) Mr. Robert A. Derwart (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2917 Erie Avenue Baltimore, Maryland 21234			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer Cemetery		Data 6/14/99		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee Michael E. Canapp <i>Michael E. Canapp</i>				22. Name and Address of Facility LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Aspiration Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Cardiomyopathy - Sepsis						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier G. Anderson MD		29c. License number D12732		29d. Date signed (Month, Day, Year) 6/11/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE A. BEDON 6701 N. Charles St. Baltimore 21204							
31. Date filed (Month, Day, Year) JUN 15 1999							

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Medical Certification: To Be Completed by Physician/Medical Examiner

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 18992

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Esther M. Forsyth				2. Date of Death Month 6 Day 7 Year 99				3. Time of Death 0152 AM					
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll					
Funeral Director	5. Social Security Number 216-28-9032		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Aug. 9, 1913		9. Birthplace (State or Foreign Country) S. Dakota	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Hampstead				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 1001A Scarlet Oak Court				10f. Zip Code 21074				10g. Citizen of What Country? U.S.A.					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse				16b. Kind of Business/Industry School					
	17. Father's Name (First, Middle, Last) Oswald Mauch				18. Mother's Name (First, Middle, Maiden Summa) Agnes Amanda Hitz									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary M. Matthews				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19000 Gunpowder Road, Millers, MD 21107									
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201				20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.													
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
State Registrar	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined													
28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier [Signature]				29c. License number D25203				29d. Date signed (Month/Day, Year) 6/7/99						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C.T. MORROW MD, CARROLL COUNTY GENERAL HOSPITAL														
31. Date filed (Month, Day, Year) JUN 15 1999				32. Registrar's Signature [Signature]										

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18993

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Jerome F. Golden</u>				2. Date of Death Month <u>6</u> Day <u>13</u> Year <u>99</u>		3. Time of Death <u>6:32 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Veterans Affairs Medical Center - Baltimore</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>215-10-9311</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>82</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>MAR. 27, 1917</u>	9. Birthplace (State or Foreign Country) <u>MARYLAND</u>
	Usual Residence of Decedent							
10a. State <u>MARYLAND</u>		10b. County <u>ANNE ARUNDEL</u>		10c. City, Town or Location <u>GLEN BURNIE</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <u>512 DOGWOOD DRIVE</u>				10f. Zip Code <u>21061</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>1941-1946</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u></u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>SUPERVISOR</u>			16b. Kind of Business/Industry <u>WESTINGHOUSE</u>	
17. Father's Name (First, Middle, Last) <u>JAMES GOLDEN</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>WINIFRED KUHN</u>				
19a. Informant's Name/Relationship (Type, Print) <u>JANICE BOYETTE (DAUGHTER)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1081 FOXCROFT RUN, ANNAPOLIS, MD. 21401</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>GLEN HAVEN MEMORIAL PARK</u>		20c. Location - City or Town, State <u>6/16/99 GLEN BURNIE, MD.</u>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</u>				
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hemorrhage. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Cardiac Ischemia</u> Due to (or as a consequence of): <u>Pneumonia</u> Due to (or as a consequence of): <u>Subdural Hematoma</u> Due to (or as a consequence of): <u>S/P CVA 5/5/99</u>						Approximate Interval Between Onset and Death <u>Minutes</u> <u>2 weeks</u> <u>2 weeks</u> <u>1 month</u>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier <u>Sheila Dunaway MD</u>		
						29c. License number <u>P-11780</u>		29d. Date signed (Month, Day, Year) <u>6/13/99</u>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Sheila Dunaway MD, VA HOSPITAL, GREENE STREET, BALTIMORE, MD.</u>								
31. Date filed (Month, Day, Year) <u>JUN 15 1999</u>						32. Registrar's Signature <u>Benjamin S. Sparks</u>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death


Reg. No. 99 18994

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner Funeral Director		1. Decedent's Name (First, Middle, Last) Marie C. Gerst				2. Date of Death Month: June Day: 10, Year: 1999		3. Time of Death 1:15 PM	
		4a. Facility Name (If not institution, give street and number) Manor Care Nursing Home - Ruxton				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
5. Social Security Number 212-12-0201		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 10, 1918		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 4313 Four Mill Road				10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 7th Grade College (1-4 or 5+):				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Charles Droll					18. Mother's Name (First, Middle, Maiden Surname) Catherine Nunnaman				
19a. Informant's Name/Relationship (Type, Print) Joseph J. Gerst (husband)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4313 Four Mill Road, Baltimore, MD 21236				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		Date 6/12/99		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </div> <div style="width: 35%;"> Approximate Interval Between Onset and Death </div> </div> <div style="margin-top: 20px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> a. Coronary Artery disease Due to (or as a consequence of): b. Aortic Aneurysm Due to (or as a consequence of): c. C.H.F. Due to (or as a consequence of): d. </div> <div style="width: 35%;"> > 1 month > 1 month > 1 month </div> </div> </div>									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18995

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MONTE D. GASE				2. Date of Death Month Day Year June 10, 1999		3. Time of Death 10:49 A.M.	
	4a. Facility Name (If not institution, give street and number) Brown's Motel, Rm 22, 8074 Balto. Nat'l Pike				4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard	
Funeral Director	5. Social Security Number 383 44 3456		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) July 21 1946	
	9. Birthplace (State or Foreign Country) Texas		10a. State Maryland		10b. County Howard		10c. City, Town or Location Columbia	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 9433 Merryrest Rd.		10f. Zip Code 21045		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Clothing				
17. Father's Name (First, Middle, Last) Manuel Aranda				18. Mother's Name (First, Middle, Maiden Surname) Gladys M. Gase				
19a. Informant's Name/Relationship (Type, Print) Ashlee E. Gase / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Torner Rd., Baltimore, MD 21221				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		20c. Date 6/15/99		20d. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee <i>Stephen D. Lohrmann</i>				22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALCOHOLISM WITH PANCREATITIS AND FATTY METAMORPHOSIS OF LIVER						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>J. Pustan, M.D.</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 11, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joseph Pestaner</i> 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 15 1999		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text, possibly a signature or date, located in the upper right quadrant of the page.

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 18996

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) JAMES ERIC GIBSON		2. Date of Death Month Day Year JUNE 10 1999		3. Time of Death 16:07
4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER		4b. City, Town or Location of Death BALTIMORE		4c. County of Death N/A
5. Social Security Number 244 56 5403	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	8. Date of Birth (Month, Day, Year) MAR. 11, 1940	9. Birthplace (State or Foreign Country) North Carolina
Usual Residence of Decedent				
10a. State Md.	10b. County N/A	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 3803 REISTERSTOWN ROAD		10f. Zip Code 21215		10g. Citizen of What Country? U.S. OF A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) UNKNOWN		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CEMENT FINISHER		16b. Kind of Business/Industry CONSTRUCTION		
17. Father's Name (First, Middle, Last) MANNIE NOAH GIBSON		18. Mother's Name (First, Middle, Maiden Surname) ROSA LEE PETERSON GIBSON		
19a. Informant's Name/Relationship (Type, Print) NOAH GIBSON (BROTHER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 MEADOWLARK PLACE DURHAM, N.C. 27712		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY 6/16/99		20c. Location - City or Town, State BALTIMORE-MARYLAND
21. Signature of Funeral Service Licensee Lewis T. Gwynn		22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTIMORE-MD.		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. MESENTERIC ISCHEMIA Due to (or as a consequence of): b. RENAL INSUFFICIENCY Due to (or as a consequence of): c. MYOCARDIAL ISCHEMIA Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1 WEEK 1 WEEK 1 WEEK
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL TRANSPLANT				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier L. Gwynn		29c. License number D52340		29d. Date signed (Month, Day, Year) JUNE 10, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ivan Rosas Johns Hopkins Bayview Medical Center Balto, Md 21224				
31. Date filed (Month, Day, Year) JUN 15 1999		32. Registrar's Signature Bernice B. Sparks		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten text at the top of the page, possibly a header or title.

Main body of handwritten text, consisting of several lines of cursive script.

Handwritten text in the middle section, appearing as a distinct paragraph.

Handwritten text in the lower section, continuing the narrative or list.

Handwritten text at the bottom of the page, possibly a signature or footer.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99-18997

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lilly May Garber				2. Date of Death Month Day Year June 12, 1999		3. Time of Death 11:15 PM		
	4a. Facility Name (If not institution, give street and number) Mariner Health of Glen Burnie				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 214-20-9681		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG 1, 1918		
	9. Birthplace (State or Foreign Country) Pennsylvania								
Usual Residence of Decedent									
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7355 Furnace Branch Rd.				10f. Zip Code 21060		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker			16b. Kind of Business/Industry Bakery		
17. Father's Name (First, Middle, Last) Guy Tenney					18. Mother's Name (First, Middle, Maiden Surname) Martha Kittle				
19a. Informant's Name/Relationship (Type, Print) Rebecca Rossback/granddaughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1356 Monaco Drive Severn, MD 21144				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 6/14/99			20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee Edward A. Gregorchik					22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. RESPIRATORY FAILURE</p> <p>Due to (or as a consequence of):</p> <p>b. PNEUMONIA</p> <p>Due to (or as a consequence of):</p> <p>c. CARCINOMA OF THE UTERUS</p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE, ATRIAL FIBRILLATION.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier R. Rangarajan			29c. License number D0054288		29d. Date signed (Month, Day, Year) June 14, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMASWAMY RANGARAJAN M.D. 7445 FURNACE BRANCH RD GLEN BURNIE MD 21060									
31. Date filed (Month, Day, Year) JUN 14 1999			32. Registrar's Signature [Signature]						

jhm
JAMES
HARLEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 18998

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Edward Harley, Jr.				2. Date of Death Month Day Year JUNE 13, 1999		3. Time of Death 08:10 AM
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a
Funeral Director	5. Social Security Number 212-70-5831	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 17, 1958	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 2902 Rock Rose Avenue				10f. Zip Code 21215		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1977		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber		16b. Kind of Business/Industry Farnen & Dermer, Inc.	
17. Father's Name (First, Middle, Last) James E. Harley, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mamie Burns			
19a. Informant's Name/Relationship (Type, Print) Father James E. Harley, Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2902 Rock Rose Avenue Baltimore, MD 21215			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veteran		20c. Date June 21		20d. Location - City or Town, State Owings Mills, MD	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, MD 21216			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Arm and Chest Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6/13/99		28b. Time of Injury 0755 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28d. Describe how injury occurred subject shot		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2902 Rockrose Ave	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number OCME		29d. Date signed (Month, Day, Year) JUNE 14, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) JUN 15 1999		Registrar's Signature <i>[Signature]</i>					

State
Registrar

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1946

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 18999

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN A. HARTMAN

2. Date of Death

JUNE 10 1999

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

COLONIAL MANOR

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

215-10-1456

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 17, 1912

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1313 WEST STREET

10f. Zip Code

21401

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

RECEPTIONIST

16b. Kind of Business/Industry

JOHNS HOPKINS

17. Father's Name (First, Middle, Last)

JAMES W. LINTHICUM

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE JONES

19a. Informant's Name/Relationship (Type, Print)

JOYCE HELVESTON / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1010 MT. HOLLY DR. ANNAPOLIS, MD. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MORELAND MEM. PARK

Date

JUNE 14, 1999

20c. Location - City or Town, State

PARKVILLE, MD.

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES
8800 HARTFORD RD. PARKVILLE, MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Dabbs

29c. License number

D24768

29d. Date signed (Month, Day, Year)

JUNE 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM DABBS, MD. 177 DEFENSE HWY. ANNAPOLIS, MD. 21401

31. Date filed (Month, Day, Year)

JUN 15 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

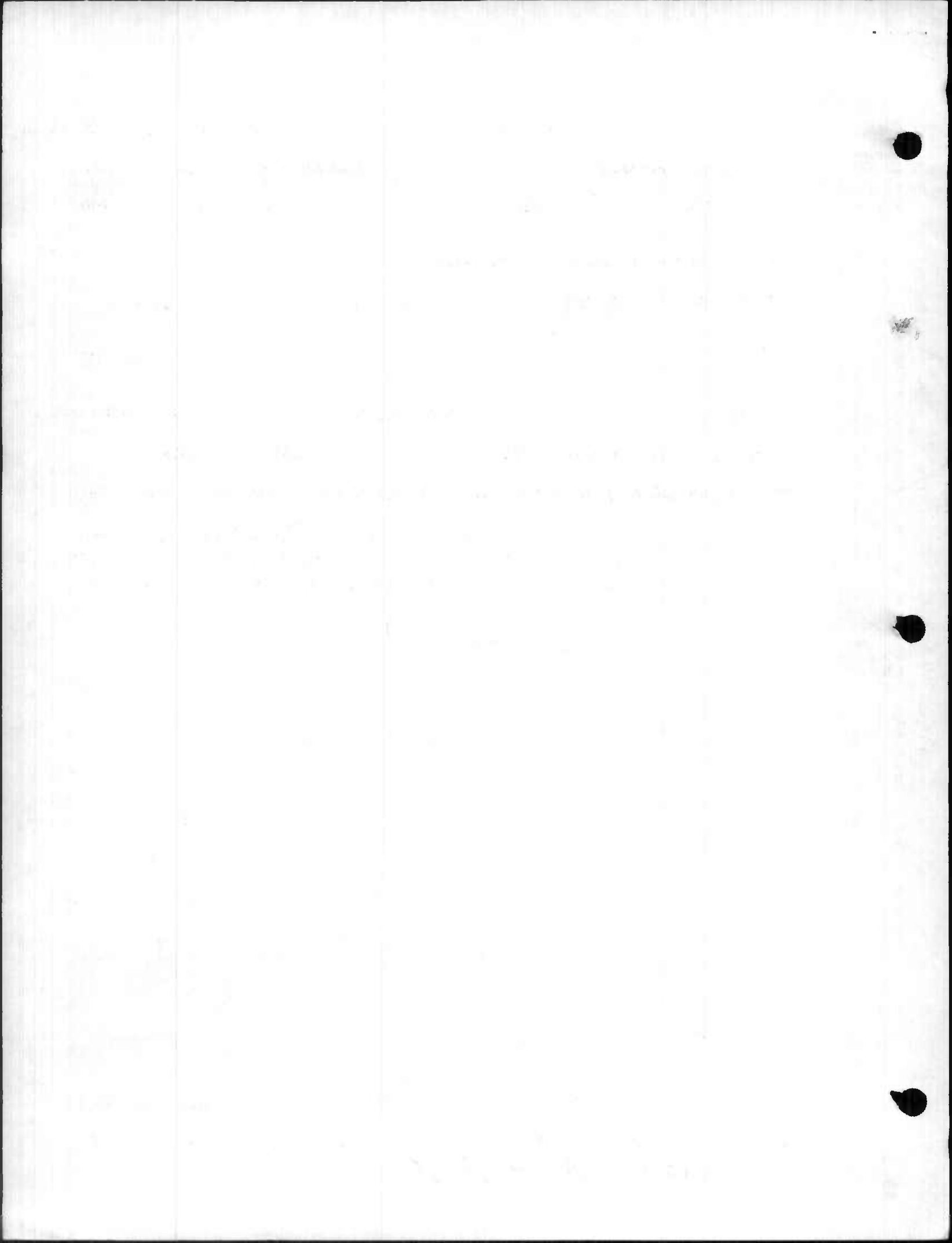
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Irene Hardin				2. Date of Death Month Day Year June 11 1999		3. Time of Death 1745	
	4a. Facility Name (If not institution, give street and number) Deaton Univ. of MD Medicine Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 220-66-5243		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 44	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05-28-55	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1830 St. Paul Street Apt. #101				10f. Zip Code 21202		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry various trades	
17. Father's Name (First, Middle, Last) Clarence Hardin					18. Mother's Name (First, Middle, Maiden Surname) Mary Saunders			
19a. Informant's Name/Relationship (Type, Print) Mary Ann Cherry					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2714 Bookert Drive Baltimore, Maryland 21225			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens 06-17-99 Dundalk, MD			20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End stage acquired immune deficiency syndrome Due to (or as a consequence of): Endocarditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Endocarditis Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 2 weeks
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number D 34974		29d. Date signed (Month, Day, Year) June 11, 1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CHARU MEHTA, MD, 8775 cloudleaf ct, #224, Columbia, MD 21045.								
31. Date filed (Month, Day, Year) JUN 15 1999			32. Registrar's Signature <i>[Signature]</i>					

Irene Hardin

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AM2

